DOCUMENT RESUME

ED 203 209 CG 015 192

AUTHOR Fabino, Robert A.
TITLE The Use of the Contract in the Treatment of Persons Who Abuse Alcohol.
PUB DATE Dec 80
NOTE 145p.: Ph.D. Dissertation, Walden University, Florida.

EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS Adjustment (to Environment): *Alcoholism: Antisocial Behavior: Behavior Change: *Behavior Modification: *Change Strategies: *Contracts: Coping: Drinking: Problem Solving: *Rehabilitation: Self Help Programs: *Therapy

ABSTRACT

Alcohol abuse is a serious problem affecting not only the individual abuser, but also family, friends and society. The effectiveness of contracts as positive tools in the treatment of alcohol abuse was investigated for 15 current abusers randomly assigned to individual therapy sessions. Each subject completed a Personal History Questionnaire, the Shostrom Personal Orientation Inventory, Cage Questions, and the Michigan Alcoholism Screening Test before participating in 12 weekly treatment sessions and again after completion of all sessions. During treatment sessions, each subject accepted and signed a contract for non-drinking behavior. Data analysis revealed that subjects attended all of the sessions. Results of the data confirm the effectiveness of the contract as a treatment tool. A symptom cure was effected, i.e., subjects moved from alcohol abuse to abstinence from alcohol. These findings supported the use of contracts in the beginning of the treatment process. (Author/NRB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED203209

THE USE OF THE CONTRACT IN THE TREATMENT OF PERSONS WHO ABUSE ALCOHOL

By

Robert A. Fabino

B.A., Roosevelt University

M.A., Roosevelt University, 1972

Helen A Cohen Ph.D.

Helen A. Cohen, Ph.D., Advisor
Professor of Psychology
University of Chicago
Chicago, Illinois

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Robert A. Fabino

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

CG 015192

A Dissertation Submitted in Partial Fulfillment
Of the Requirements for the Degree
Of Doctor of Philosophy

WALDEN UNIVERSITY

December 1980

To

George and Chuck

kevin, helen, mother, joe, ron, warren, teddy, ray,
greg, grandma, ruth, karen, michael, larry, deric,
jerry, mark, kenny, tom, bob, art, jim, roger, jo,
jess, ro, ken, lois, kathy, gene, luke, oz, a,
rhonda, bill, laney, terry, tom, terry, george,
les, myrtle, natalie, damien, dan, sharon, jimmy,
rocille, ed, mary ellen, arline

THE SLEEPER OF THE VALLEY

There's a green hollow where a river sings
Silvering the torn grass in its glittering flight,
And where the sun from the proud mountain flings
Fire--and the little valley brims with light.

A soldier young, with open mouth, bare head,
Sleeps with his neck in dewy water cress,
Under the sky and on the grass his bed,
Pale in the deep green and the light's excess.

He sleeps amid the iris and his smile
Is like a sick child's slumbering for a while.
Nature, in thy warm lap his chilled limbs hide!

The perfume does not thrill him from his rest.
He sleeps in sunshine, hand upon his breast,
Tranquil--with two red holes in his right side.

--Arthur Rimbaud, Author
1854-1891
--Ludwig Lewisohn, Translator

ACKNOWLEDGMENTS

The author gratefully acknowledges the many people who consciously and unconsciously have helped him in the preparation of this work. Without their support, encouragement, and understanding, this work would not have become a reality.

To my special and dear friend, mentor, and teacher, Doctor Helen Cohen, who has pushed, supported, and encouraged me from the days when I first began my educational adventure.

For their time, efforts, interest, and critiquing comments, as well as their support, I am appreciative of Doctor Alex Haggis and Doctor Egbert L. Pfeiffer.

For the work of Ray E. Bishop III and Sheila D. Hanrahan, a special thanks. First, for giving their time as therapists to this project, and second, for helping to make my life more liveable throughout the research aspect of this study.

My words seem limited when I attempt to express my immense appreciation for Suzanne Meneses. Her contributions and efforts in the final preparation and typing of this manuscript will always be remembered and treasured.

TABLE OF CONTENTS

DEDICATION ii

ACKNOWLEDGMENTS. iii

LIST OF TABLES vi

LIST OF ILLUSTRATIONS. viii

Chapter
I. INTRODUCTION. 1

The Problem 1
Historical Perspective. 3
Controls and Regulations. 4
Cultural confusion. 5
Research Programs 8
Definition problems 8
Abstinence From Alcohol Versus Controlled Drinking. 12
Alcoholism. 14
"Clues" to aid in the diagnosis of alcoholism . 15
Promises - promises - promises. 20
Development and life posture. 21
The parent. 24
The adult 24
The child 25
Life posture. 26
Arrested Development. 28
Attitude and Behavior 30
Expectancy theory 31
Realistic expectations. 34
Self-Perception 34
Expectations of success or failure. 35
Relearning. 38
Self-concept and learning 38
Positive Relationship 41
Change in terms of human behavior 46
Intervention for change 49
Treatment of a Symptom. 50
Ego-reduction 54
Contractual Treatment 58
Goal Setting. 60
Contract Elements 61
Contract Renewal. 62

Purpose of the Study. 63
Hypothesis. 64
Importance of the Study 64

Chapter
II. DESIGN AND METHOD 72

Overview of Study 72
Definition of Terms 73
Description of the Sample 73
Subjects. 74
Procedures. 75
Instrumentation 77
Analysis of the Data. 79
Results 82
Discussion. 105
Summary 109

. . . . . .

APPENDIX 111

BIBLIOGRAPHY 125

LIST OF TABLES

1. Rates of Problem Drinking 66
2. Estimated Deaths 67
3. Economic Costs 69
4. Trends in Alcohol Consumption 71
5. Expectation of Mean Squares 81
6. Demographic Information 84
7. Variable 1--Cage Questions 85
8. Variable 2--Michigan Alcoholism Screening Test . . 86
9. Sessions Attended--No. of Contracts Kept 87
10. Variable 3--Time Competence, 2 Way Analysis of Variance Repeated Measurements 88
11. Variable 4--Other Directed, 2 Way Analysis of Variance Repeated Measurements 89
12. Variable 5--Self-Actualizing Values, 2 Way Analysis of Variance Repeated Measurements . . . 90
13. Variable 6--Existentiality, 2 Way Analysis of Variance Repeated Measurements 91
14. Variable 7--Feeling Reactivity, 2 Way Analysis of Variance Repeated Measurements 92
15. Variable 8--Spontaneity, 2 Way Analysis of Variance Repeated Measurements 93
16. Variable 9--Self-Regard, 2 Way Analysis of Variance Repeated Measurements 94
17. Variable 10--Self-Acceptance, 2 Way Analysis of Variance Repeated Measurements 95
18. Variable 11--Nature of Man, 2 Way Analysis of Variance Repeated Measurements 96

19. Variable 12--Synergy, 2 Way Analysis of Variance Repeated Measurements 97

20. Variable 13--Acceptance of Aggression, 2 Way Analysis of Variance Repeated Measurements . . . 98

21. Variable 14--Capacity for Intimate Contact, 2 Way Analysis of Variance Repeated Measurements . . . 99

LIST OF ILLUSTRATIONS

1. Selected Mortality Rates 68
2. Per Capita Ethanol Consumption 70
3. Groups I, Pre-Post Averages 101
4. Group II, Pre-Post Averages 102
5. Groups I, II, Pre-Post Averages 103
6. Group III, Pre-Average 104

vol 9

CHAPTER I

INTRODUCTION

The Problem

Alcohol-abuse is a serious problem. There exists a population of individuals who have abused and continue to abuse alcohol. In the adult population of the United States, it is estimated that there are up to 10 million problem drinkers. Of the adults who drink, 36 percent either have current or potential drinking problems. An estimated breakdown of these special population groups shows that there are 3.3 million problem drinkers in the 14-17 age range, or 19 percent of the 17 million persons in this age group. See Table 1.

Alcohol-related deaths may run as high as 205,000 per year. This figure includes deaths from accidents, homicides, suicides, and various life-threatening diseases. See Table 2.

Deaths from cirrhosis, a disease frequently associated with alcohol, rose 36.6 percent from 1960 to 1970. See Illustration 1.

The cost of alcohol-abuse to the United States was nearly $43 billion in 1978, $25 billion in 1974, and $15 billion in 1971. See Table 3.

We can expect the problems related to alcoholism and alcohol-abuse to increase. See Table 4. It is clear that particular population groupings will continue to be unstable: (1) a genetic predisposition factor has not been discovered, (2) there is a population that develops over a long period of time a negative sensitivity to alcohol, and (3) in the area of prevention for both populations, detection through early diagnosis has not been successful.

In the area of prevention, studies have established the importance of environmental influences (especially those impinging on persons early in life) on perceptions, attitudes, and values. This clearly applies to attitudes learned early in childhood about alcohol. Studies have centered around: alcohol-related problems among high school students; drinking patterns among college students; responsible use and non-use of alcohol; "counter culture" movement; region, urban, and social class differences; why alcohol-problems increase and diminish over periods of time; cross-cultural and cross-national studies; and finally, the effects of local alcoholic beverage control laws. The major conclusion of studies in these areas--"insufficient insight available."

Since 1971, the per capita consumption of alcohol has increased and reached the highest level since 1850. See Illustration 2. The problem of increased consumption is reflected in the following issues: (1) since population characteristics influence the quantity and frequency of

alcohol use, and these populations are constantly changing, interpretations of the relationship(s) between drinking patterns and population characteristics are more difficult; and (2) early drinking behavior predicts drinking habits in later life. In addition, we note that increased availability of alcohol has occurred as a result of lowering the drinking age.

Historical Perspective

Concern for the limits of human possibility in dealing with alcoholic beverages has required man to establish regulations, controls, and rules of conduct for behavior since the time of the Babylonian Code of Hammurabi around 2000 B.C. to modern times. Control of alcoholic beverages from a historical perspective has always been a problem. According to Anderson (1967), the laws in China from 1312 to 1134 B.C. against drinking were passed and repealed no less than forty-one times. Laws to control alcoholic beverages were based on the assumption that the fatal negative effects outweighed the fatal positive effects. Yet man throughout history continues to explore and search for ways to establish, incorporate, and control drinking behavior as part of his human nature. The intake of alcoholic beverages is considered part of human culture, and many social and religious events include as standard practice the use of alcohol.

With the discovery of distillation in the Middle Ages, changes in drinking behavior occurred within Europe;

and with the increased spread of spirits, there was also the advancement of world problems. Distilled spirits spread rapidly from England to the North American colonies. The use of alcohol and a shift in attitudes and behavior has been attributed to a number of factors: "the inability of the colonists to find appropriate sales for viticulture, the extremely poor transportation facilities making the distribution of bulky materials like beer quite uneconomical, a restrictive British colonial policy on wine imports, the magnificent resources for developing cereal products, and a whole variety of economic and other factors which resulted in the extremely profitable triangular traffic in New England rum, African slaves, and West Indian sugar cane" (Anderson 1967).

Controls and Regulations

The shifting of controls and regulations toward drinking attitudes and behavior has characterized the American scene from early colonial days. In review, we see that the early colonists coming to America found what had not been granted to them in Europe--a land without regulatory agents, rules, strict government, personal controls, or social controls. It would seem that the loosening of controls in these areas would also imply the loosening of controls over the use of alcoholic beverages. History has demonstrated that latter point to be accurate. The complexity of the scene continued to grow from the already described loosening of controls, self-imposed controls,

community controls, social controls, to a period of abstinence enforced and supported by federal legislation, and finally our current picture in which we note a confused and ambivalent attitude toward alcohol. The operational definitions that would provide the individual with an acceptable regulation are not yet available. So we have in our culture a population who abuse alcohol and another population who represent future problems.

Cultural Confusion

The search for crystallized cultural guidelines as to the conduct of human possibility for attitudes, values, and behavior of common mental health positions has led people to the church, the government, Alcoholics Anonymous, and the Health Care Field. The dissonance between the needs of the individual, the culture, and success of support by these major groups has been extreme, checkerboarded, and unfulfilling. These combined efforts have neither blended well nor been in harmony with the individual and alcoholic beverages. Results have been minimal, varied, and confused.

The attitudes toward drinking are generally favorable and permissive as long as drinking is done with moderation and with controls. An equally unfavorable attitude exists when there is heavy drinking or the loss of control. However, the problem is not that simple. In the range of distance from the statement of favorable to unfavorable, controlled to loss of control, we can see the deep expression of conflict that exists within the field of study and

society as a whole. Rules are diverse and vague, and precise operational behavioral guidelines simply do not exist.

Traditional mores generally held that if a person is sinful, the community bears no responsibility to help him; whereas, if the person is sick, there is often a social sanction to provide rehabilitation services (Pattson, Sobell 1977). If the individual wants, he can control his drinking behavior. The assumption is that their behavior is a self-inflicted condition. And yet for some, excessive drinking is at times a major problem. As a result, supportive help for cure requires that one embrace a sick-role position. Other options are overlooked or by-passed.

Outdated folklore type explanations as to the etiology of alcohol-dependent people abounds within the field. As might be expected, these explanations and discussions of alcohol-abuse and dependency are questionable and occur within a major social area of man's life that is emotionally volatile and crowded with differences of opinion. It is important to remember that, with the particular state of the art, these explanations need not necessarily be discontinued as long as these attitudes are not demandingly dictated to the scientific community or the serious student of alcoholism.

Has the label of disease helped? The definition of a disease states that it is a social process. Yet alcoholism considered as a disease presents positive, negative, and

questionable characteristics. From the positive perspective the disease definition has: (1) assisted in the development of professional and rational approaches to treatment, (2) removed discriminating practices in hospital and insurance coverage, (3) reduced punitive and moralistic efforts to cope with alcohol-abuse problems, and (4) produced legislatively supported programs. From the negative perspective there are: (1) the classification of a disease without evidence as to the etiology of alcoholism, the absence of evidence supporting a theory of genetic predisposition that has prevented the development of casual factor treatment programs; and (2) the opportunity that has been created for people to diagnose themselves and others, without controls and differentiation, as being alcoholic and having a disease which is not curable.

For change of behavior to occur, from a position of destructive drinking behavior to a position of rehabilitation, it is required that there be a consciousness and awareness of the relationship of alcohol to human problems and functioning. There is needed a uniformed understanding of the various forms of drug dependence and of how the individual organizes his life around alcohol.

Society and Health Care Practitioners need to move away from historical either-or-thinking to the arena of risk and the conditions and limits of human possibility. Rehabilitation has to be tailored to the individual needs of the patient and his resources. Research and treatment programs

designed to reduce or deal with alcohol-related problems must center around physiological, psychological, and sociological evaluations. There is no single magic cause or cure. Exploration needs to question whether or not a combination of factors needs to be present for alcohol-related problems to develop.

Research Programs

The Third Special Report to the U.S. Congress on Health states: "Systematic, well-designed studies of treatment effects are rare, particularly those that have used random assignment of subjects to controlled and experimental conditions. Few differences in effectiveness among treatment settings, types, and duration have been identified."

Although many treatment resources exist, most people with alcohol-related problems do not receive treatment. Barriers to treatment are: social stigma, the fear of being identified as having a drinking problem, which restricts individuals from seeking treatment; denial of a drinking problem by the individual and those around him; refusal of professionals to work with individuals having a drinking problem; failure to identify and diagnose the health problem; resistance to treatment based on the individual's belief that help is not really available; and inadequacies of health care delivery systems.

Definition Problems

The confusion and ambiguity that exists within the Health Care Field are multiple and contradictory. Noble

(1978), in the Third Report to Congress on Alcohol and Drug Abuse, states that the recommended and considered position of the National Institute on Alcohol Abuse and Alcoholism should be total abstinence from alcohol for the treatment of alcoholism, a position that clearly parallels the official position of Alcoholics Anonymous. Steiner (1972) supports a return to controlled drinking. Chafetz, in his 1967 article entitled "Liquor: The Servant of Man," discusses the positive aspects of alcohol, ". . . in particular its use as an aid to human relationships and as a means of increasing self-awareness." The author asks us to consider the perception of reality and its alteration by a drug as being positive in nature.

Supporters from both major perspectives are aligning themselves into strong camp positions; yet, the simplicity of their position requires careful evaluation. Considering the historical perspective of the general failure of human possibility in controlling alcohol by abstinence, with minimal evidence of long-term achievement, the current movement and enchantment with human rights, it becomes possible to speculate that the movement toward having an individual return to controlled drinking is in fact an admission of failure. It also seems reasonable to speculate that people who have a history of alcohol abuse have not learned normal patterns of drinking behavior. Therefore, it may be impossible to relearn patterns of drinking behavior. However, the real problem with understanding alcohol-abuse is within

the area of definitions of population, social background, physical development, and individual learning style.

In a field plagued by minimal research evidence, a willingness to grab at psychological theories, and construction of factor explanations without rigorous standards of evidence, the importance of developing operational statements becomes increasingly critical.

Where do the responsibilities of the Health Care Field activities lie in terms of the humanistic matching of the needs of the individual, the statement of guidelines for control of behavior, and the commitment of the culture? The complexity of this definition task is enormous and requires a consciousness of statements that are reflections of reality and not simply a support of current fads, a submission to economic or political pressures, or a statement for individualistic glory. So alignment in dealing with the creativity of controlled drinking versus abstinence may not represent directions that reflect a unified developmental theory, but rather an attempt to solve problems by providing answers that are faddish and that attempt to control the problems of social- and interest-group pressures.

Frequently, we find etiological statements based on self-interest group statements. For the researcher, the search into the causes of alcoholism and alcohol-abuse must reflect a multidimensional model. However, more precise methodology is required for extrapolation to a larger

population. This problem is further complicated by the lack of accepted definitions as to what constitutes alcohol-abuse.

One limiting feature to research has been the confusion that exists in attempting to define the exact nature of alcoholism. Efforts at differentiating alcoholism from alcohol-abuse and problem drinking has further complicated the picture. The problem is amplified by the lack of specific information about the characteristics of populations and subpopulations for the category of alcoholism, alcohol-abuse, and the problem drinker.

With these problems in mind, in order to plan intervention for change, defined in terms of treatment outcome and goals, we again must recognize a similar set of issues in trying to define various categories of alcohol-abuse as matched with planned strategies for treatment. Attempts to control man's behavior in terms of his relationship to alcohol has a confused and ambiguous history. Rules of conduct regarding behavior were established, changed, and reestablished. For most, the rules of conduct have worked. For some, abuse of the drug, alcohol, requires a different set of behavioral patterns than that required for those who have what we would call a "normal" set of drinking behavioral patterns. The church, punitive and moralistic acts, legislation, and preventive education have not been able to effectively deter those who abuse alcohol. Against this emotionally volatile backdrop, people who abuse alcohol seek help in changing their behavior.

In defining legitimate and feasible goals for outcome of treatment, we can begin by using such global terms as cure or recovery. However, the more specific treatment goals center around abstinence from drinking, controlled drinking, or a multidimensional rehabilitation program. More precisely stated, the outcome of therapy has at its foundation the purpose of changing drinking behavior from a pathological alcoholic drinking pattern to some type of non-problem drinking.

Abstinence from Alcohol Versus Controlled Drinking

In the 1978 Third Special Report to Congress on Alcohol and Health, the conflict between abstinence as a goal versus controlled drinking as a goal was expressed:

> A major ideological issue within the field involves abstinence versus controlled drinking. Efforts are being made to gather valid data for differentiating these clients for whom the one goal is appropriate, feasible, or desirable from the other. The National Institute on Alcohol Abuse and Alcoholism, however, continues to endorse abstinence as the most appropriate treatment goal for alcoholism. While change in drinking behavior remains the primary goal of most treatment programs, increasing attention is directed toward psychological, social, and vocational criteria.

This position receives major support from Alcoholics Anonymous, who stress abstinence from alcohol as the only way to deal with alcohol-abuse and alcoholism. They reflect the "Traditional Approach," stressing abstinence because of

the rationale of the disease model and because of the belief that alcoholism as a disease is a progressive and irreversible disorder whose only pathway to recovery is abstinence.

Disparity of the research data available suggests that Alcoholics Anonymous may not be as successful as many would believe. Specific data for improvement rates is difficult to obtain. C. (1965) reports 34.6 percent of A.A. members are abstinent at the end of one year. Ditman (1967) estimates 30-35 percent "cure" rate for all A.A. membership. This data is contrasted with the works of Forrest (1973) and Gelman (1964) who report a 75 percent improvement rate at the end of one year, or the report by A.A. itself (1972) which reports a 60 percent improvement rate at the end of one year.

As a tool for recovery, A.A. does work for some. However, three issues arise in reviewing the research data. First, in contacting A.A. individuals, acknowledging and accepting their drug-abuse behavior, identify themselves as "alcoholics." The label "Alcoholic" is applied without differentiation to everyone in the organization. Although the label may describe some dimensions of behavior, it does not contribute to the differentiation of populations within the membership. Second, the low "cure" percentage and the high drop-out rated, reported by C. (1965) and Ditman (1967), raises question as to the value of A.A. as a viable tool in the recovery process. Further doubt arises when one

considers the possibility of a spontaneous cure rate of 30 percent for a given population. And third, the use of the twelve-step program for everyone on "the program" needs review. There is positive value in self-help programs. The value of applying the same program to everyone within the same population without some form of control becomes impossible to assess.

Alcoholism

Progress in the design and development of research, treatment plans, and individual rehabilitation programs can only occur when built upon a very careful and explicit language that reflects the exact and real nature of the phenomena being discussed. A definition of alcoholism is difficult to establish.

The American Medical Association (1968) provides the following definition:

> Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by a tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustment as a direct consequence of persistent and excessive use of alcohol.

Utilizing this definition, alcoholism is identified as an illness. However, in the same publication--AMA--in providing guidelines to aid in the diagnosis of alcoholism,

states". . . once the possibility of the disease is considered because of these 'leads' . . . ."

"Clues" to Aid in the Diagnosis of Alcoholism

The following "clues," should serve to arouse the physician's suspicions that his patient is suffering from alcoholism. Needless to say, they will not all apply in every case. Once the possibility of the disease is considered because of these "leads," comprehensive evaluation is indicated.

Alcoholism should be suspected if there is:

1. Increasing consumption of alcohol, whether on a regular or sporadic basis, with frequent and perhaps unintended episodes of intoxication

2. Drinking as a means of handling problems or relieving symptoms

3. Obvious preoccupation with alcohol and the expressed need to have a drink, especially if habitually repeated

4. Surreptitious drinking or gulping of drinks

5. Tendency toward making alibis and weak excuses for drinking

6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned

7. Frequent absenteeism from the job, especially if occurring in a pattern, such as following weekends and holidays (Monday morning "flu")

8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education, and background

9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations

10. Persistent vague somatic complaints without apparent cause, particularly those of insomnia, gastro-intestinal difficulties, headaches, anorexia

11. Persistent marital and family problems, perhaps with multiple marriages

12. History of arrests for drunkenness or drunken driving

13. Coarse, unexplained tremors of the hands

English and English (1958) describe alcoholism as "(1) a tendency to excessive use of alcohol, (2) a personality disturbance whose most prominent symptom is chronic compulsive drinking, (3) a pathological condition of body or mind, resulting chiefly from excessive drinking." In this definition drinking is defined as a cause and drinking is seen as an effect or symptom.

Jellinek contributed greatly to the popularization of the concept of alcoholism as a disease. It was Jellinek (1952) who in Phases of Alcohol Addiction formulated distinctions between categories of alcoholics--alcohol addicts and habitual symptomatic excessive drinkers, and who states that the disease concept refers only to the alcohol addict.

His formulations are based on the key variable of "loss of control." Jellinek carefully developed phases of addiction with discrete statements as to the progression of the disease from prealcoholic phase to prodromal phase to crucial phase to chronic phase. The work of Jellinek is of major social significance in the early attempts to define alcoholism as a chronic disease. Keller (1960) states there is no known causative agent, no definitely known etiology, and the origin is presumed to be in the "psyche." Despite these statements, he still maintains that alcoholism is a disease. The later works of Haff (1968) and Room (1970) state that the available evidence does not support the concept of progression of symptoms, or a significant matching of behavior that is occurring in reality.

Mann (1958) provides a simple definition: "An alcoholic is someone whose drinking causes a continuing and growing problem in any department of his life." The definition is a combination of the theories of Jellinek and the guidelines of Alcoholics Anonymous. The essential characteristics of alcoholism are a compulsion to drink, a dependence on alcohol, and a life built around alcohol.

The World Health Organization (1952) has provided a definition of alcoholism and a definition of an alcoholic. "Alcoholism is a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health or his social or

economic function." Here is noted a definition that is descriptive and symptomatic rather than etiological. "Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their physical and mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments." Again, another definition that narrowly states alcoholism is a disease.

The Modern Synopsis of Psychiatry (1972) states that "Alcoholism is a chronic behavioral disorder motivated by an undue preoccupation with alcohol and its use to the detriment of physical and mental health, by loss of control when drinking is begun, and by a self-destructive attitude in dealing with personal relationships and life situations." Going further, the same work states the following in reference to etiology: "Alcoholism results from a disturbance and deprivation in early life experiences and the associated related alterations in basic physiochemical responsiveness, from the identification by the alcoholic person with significant figures who deal with life problems through an unhealthy preoccupation with alcohol, and from a sociocultural milieu that causes ambivalence, conflict, and guilt in the use of alcohol."

Chafetz (1967), from a holistic perspective, states that "Alcoholism is a chronic behavioral disorder manifested

by an undue preoccupation with alcohol and its uses to the detriment of physical, emotional, and social function."

Berne (1961) and Steiner (1972) believe that alcoholism is not a disease but rather a conscious decision, a script theme from early childhood. The ego of the individual is described in three parts: the Parent, the Adult, and the Child. The Child says, "How do I get the critical Parent off my back? The Adult isn't helping. Aaa--alcohol--when I drink, the critical Parent is gone, what a relief (a deep relief)." However, the decision is multidimensional and complex. Instead of just being an inner psychological decision, it is also a physical decision, and subsequently, an external social decision.

Proceeding in a different direction in order to avoid the labeling process and to reorganize the functioning rather than any specific behavior, Callahan (1970) suggests the definition of Plout. "Problem drinking is a repetitive use of the beverage, alcohol, causing physical, psychological, or social harm to the drinker or others." Again, as with other definitions, difficulties are encountered in establishing causality in relation to the problem. As with the preceding definitions, except for Steiner, the same single question arises. What comes first, the drinking or the problem? Did the drinking cause the problem or did the problem lead to drinking?

Progression from alcohol abuse to alcoholism is highly individualized and may be a short journey or a

prolonged trip. All alcoholics are not the same. It is important to differentiate between the drinking behavior of alcoholics from that of other drinkers, especially, in the area of loss of control. Also, to explore if tolerance for alcohol results from many years of heavy drinking, or if the sensitivity to alcohol is a genetic predisposition. At least some of the personality conflicts and problems are probably a consequence of long-standing drinking problems rather than a cause. The complexity involved in a search for a cause is clearly stated by AMA (1968) ". . . most authorities now agree there is no simple cause but rather a complicated interplay of physiological, psychological, and sociological factors which lead to the origin and development of alcoholism."

In attempting to build a definition, Weissteen (1968) states, "Even when psychological theory is constructed so that it may be tested and rigorous standards of evidence are used, it has become increasingly clear that in order to understand why people do what they do, and certainly in order to change what people do, psychologists must turn away from the theory of the causal nature of the inner dynamics and look to the social context within which individuals live." Harmful behavior is the behavior that can be predicted from the social situation, along with the individuals' history.

Promises - Promises - Promises

Recognition of this occurrence in behavior is simple. An alcohol abuser, for example, drinks to excess, recovers,

and frequently promises through an internalized process of subvocal communication and thinking never to repeat the drinking behavior. However, given the passage of time, elimination of alcohol from the bodily systems, physical improvement, and forgetting as a defense, the abuser finds himself again in a similar position. Then, with or without awareness of the internal conflicts, he repeats the same drinking behavioral cycle, usually followed by another promise of reform. A cycle is established and reinforced.

Development and Life Posture

The discussion of the developmental history of the individual has traditionally been approached from a variety of viewpoints. Included within these various theoretical models are such variables as genetic predisposition, physiological progress, muscular-motor-coordination, social skills, and interpersonal relations. Freud, Adler, Erikson, Jung, Piaget, Sears, and Havinghurst have placed major emphasis on the development and organization of the individual personality. Detailed within each of their systems is the sequence and integration of development over a given period of time.

Each system is complex and has evolved within the framework of a particular rationale that accounts for human growth from perspectives of philosophy, neurological functioning--a medical model, and the zeitzeist of the authors' particular period. Freud, for example, placed emphasis on

sex and agression, Adler on inferiority, and Erikson on an extended period of what he called psychosexual development.

Following a personal disappointment with his experiences in psychoanalytical training, Eric Berne began rethinking about how man develops and began a long personal history of publishing which began in the year 1939 and is followed by several major seminal articles which led to the volumes presenting his theoretical position.

Central to the theory of Transactional Analysis and the developmental history of the individual are the following:

1. The brain functions as a high-fidelity system.

2. The feelings which are associated with past experiences also are recorded and are inextricably locked to those experiences.

3. Persons can exist in two states at the same time. A patient knew he was on the operating table talking with Penfield; he equally knew he was seeing the "Seven-Up Bottling Company . . . and Harrison Bakery." He was dual in that he was at the same time in the experience and outside of it, observing it.

4. These recorded experiences and feelings associated with them are available for replay today in as vivid a form as when they happened and provide much of the data which determines the nature of today's transaction. These experiences not only can be recalled but also relived. I

not only remember how I felt, I feel the same way now" (Harris 1967).

The individual throughout his life is continually confronted with opportunities for interaction with other human beings. This unit of social intercourse is called a transaction. "If two or more people encounter each other . . . sooner or later one of them will speak or give some indication of acknowledging the presence of the others. This is called a transactional stimulus. Another person will then say or do something which is in some way related to the stimulus, and that is called the transactional response" (Berne 1964).

Continual observation supports the assumption that people exist in three distinct ego states of awareness. Technically they are called exteropsychic, neopsychic, and archaeopsychic ego states. Colloquially, they are labeled and exhibitions of the Parent, Adult, and Child. These are the recordings in the brain of actual experiences of internal and external events, the most significant of which happened during the first five years of life.

These states of being are not roles but psychological realities. Berne says that "Parent, Adult, and Child are not concepts like Superego, Ego, and ID . . . but phenomenological realities" (Berne 1961). These states are produced by the playback of recorded data of events in the past involving real people, real times, real places, real decisions, real feelings.

The Parent

The Parent consists of brain recordings, perceived and incorporated by an individual in the early years of his life, especially up to the fifth year of living. This is the most important period, since everything the child sees or hears his parents doing are recorded in his own Parent. In retrospect, it is important to remember that these recordings are imposed unquestioned and external to the child and represent a learned position and attitude toward life and oneself.

The child in a situation takes in information, records without editing, does not modify or correct. That which is recorded is considered to be accurate and correct. These recordings will include the rules of the parents as well as the positive "benevolent" pleasures of the child's parents. The question here is not whether these rules were good or bad in light of current societal or parental rules, but rather that the child has recorded them as they are. He has experienced the formation of a permanent recording which is supported by the research findings of Penfield. These recordings cannot be erased and are available for replay throughout life. They will continually have a profound influence upon the individual in his lifetime.

The Adult

Balancing the imbalance that exists and potentially exists between the Parent and Child is the Adult. Harris postulates the beginning function of the Adult around ten

months of age. Initially, the beginning of the child's power begins with locomotion, followed by the handling and manipulation of objects. Evidence for this is supported by the studies of Gesell and Ilg. Growing from the child's awareness that he is able to do something is the beginning of the formation of the Adult.

"The Adult is . . . principally concerned with transforming stimuli into pieces of information and processing and filing that information on the basis of previous experiences" (Berne 1961). The Adult is a judgmental data-processing computer dealing only in fact. Two plus two equals four.

The Child

The recordings of internal events (feelings) are the individual's response to external events. These are primarily what the person sees or hears, what is occurring between mother and father, from birth to age five, a felt concept of life.

Penfield observed that the subject feels again the emotion which the situation originally produced in him, and he is aware of the same interpretations, true or false, which he himself gave to the experiences in the first place. Thus evoked recollection is not the exact photographic or phonographic reproduction of past events or scenes. It is reproduction of what the patient saw and heard and felt and understood.

This seeing, hearing, feeling, and understanding is called the child. However, since major data recordings occur prior to the development of language-vocabulary skills, most reactions are feelings. Unfortunately, because of the child's dependency, lack of vocabulary, and motor skills, recordings are "as if" they are forever, amen, never to change. If the recordings are positive, the child is positive and successful; if the recordings are negative, a negative life posture is assumed.

Life Posture

As a result of the early recordings of the brain and experiences, the individual makes a decision toward life, toward himself, and toward others. The decision is recorded and will influence everything he does. Because these postures are decisions, they can be changed by a new decision once it is understood.

The child moves rapidly from a state of symbiotic intimacy within the experience of separation to the moment of Psychological Birth that first reestablished bodily contact necessary to survival. These on-off experiences will continue within the first five years of life and, unfortunately, it is complicated because of the absence of a well-balanced set of tools for decision-making. Because of this situation, the child is required to seek changing forms of support in a transaction with another human being.

As a result of seeking this state of equilibrium, the child decides his life position. This central affecture

emotional position, once established, becomes the position which one returns to automatically for the rest of his life.

Every person in the early years of development, from birth to approximately age five, decides upon how he will feel and act toward life, toward himself, and toward others. This decision is observed when an individual decides upon one of the following four (4) life postures:

1. I'm not OK - you're OK
2. I'm not OK - you're not OK
3. I'm OK - you're OK
4. I'm OK - you're not OK

Whichever life posture is selected will be recorded in the brain and serve as the on-going permanent guidelines for behavior for the rest of the person's life. Because we are dealing with a decision, it is possible when understood by the individual for a redecision on his life posture to occur.

Positions are decided upon by the end of the second year of life or sometime during the third year. At this time the child has decided on one of the first three positions. Harris states that position #1 is a tentative decision based upon experiences of the first year and, by the end of the second year, it is either confirmed or has receded to the positions #2 or #3. On the decision of his life posture, once chosen, the individual will govern his life, himself, and his relationship with others based upon his orientation.

Piaget would call these positions "intellectual elaborations in the construction of causality." In Transactional Analysis, they are the product of adult data processing in a very little child.

Having decided upon a life posture, the individual approaches life, learning, and situations with expectations of success or failure. These expectations are not grounded on a solid logical decision of objective capabilities or abilities, but rather they are strongly determined by their feelings of achievement, willingness to try new tasks, and feelings of competence. Research studies (Boigan 1968; Argyle 1964; Hess and Bradshaw 1970; Locke, Bryan, and Kendal 1968) all reported a positive relationship between outcome of performance and subjects' expectations of success and failure.

Arrested Development

The personality of the alcoholic and alcohol abuser, in different degrees, suffers from arrested development. This is reflected by the immaturity of ego functioning, poor self-attitude, and by the highly structured role-playing in relationships and the erection of facades. Also, one notes egocentricity, marked with periods of defiance or dependency, continuing rationalizations, and failure to learn from past experiences. With the alcoholic we see excessive drinking, exaggerated dependency on alcohol, and progressive loss of control over the amounts of alcohol ingested, a general withdrawal from social activities into

isolation and a strongly protected denial system. There is an ongoing lack of trust in themselves, other people, and the world. There is a failure to see that their own actions have something to do with the pleasant or unpleasant events within their lives.

The social history of mankind has not only permitted but has, in fact, encouraged alcohol ingestion. Drinking has come for many to be associated with promotions, religious events, a general time of celebration, and party drinking. And yet, for a major segment of the population, alcohol has come to be used to help a person sleep, adjust to an immediate personal crisis, a combatant to loneliness and boredom, stress, adjustment to disappointment, a provider of relief from the tensions experienced within the individual, and as a vehicle for adjusting one's perceptions of reality. Inappropriate drinking progressively affects not only the problem drinker but also the lives of others: family members, co-workers, employers, friends, and innocent bystanders. With people who abuse alcohol, we frequently see a deterioration of the internal mechanism of the ego structure, an ongoing reinforced negative self-image, negative self-image, negative feelings about oneself, a diminished expectation of improvement, conflicts within interpersonal relationships, object fixation, exaggerated response to social pressures, and a deep-seated pessimisn that we cannot trust ourselves.

Attitude and Behavior

When, in our daily world with our purposes and objectives, one is confronted with new situations, one attempts to adjust to them with specific behavior based upon past experiences. New situations call upon our resourcefulness and our ability to reorganize and adapt established response patterns to the present demands. Sometimes one is confronted with situations too novel or too demanding for our resources. At other times one may be frustrated or prevented from doing what is considered to be appropriate.

When an individual is repeatedly frustrated in his goal-directed activities, when attempts at constructive action are minimized or blocked, a state of limited behavioral responses may be established. Rewards for particular goal-directed activities tend to elicit continued behavioral responses.

According to Festinger (1962), attitudes and behavior that are consonant produce higher performance results that are consistent with the individual's expectation. For example, if the individual believes that learning and education are important and has previously been rewarded on some regular reinforcement schedule, it is probable that this individual will respond with higher performance in those situations that are similar and are experienced as being valuable. Usually a change agent will be able to motivate this person simply by explaining the value of the materials to be learned. Attitudes and behavior that are dissonant

produce lower performance results which may indicate that a gap exists in the attitude one has about oneself and the value of one's behavior. A person who abuses alcohol can be said to have a positive value toward alcohol, even though his behavior may be destructive and dissonant with a larger segment of the society in which he lives. Values are displayed by people to meet needs, and values are judged by one's behavior. Defensive values inhibit personal development. Values can be used to maintain self-attitude needs, with poor self-attitude being maintained by the use of defensive values. Values affect and are in turn affected by the process of thinking, believing, feeling, and behaving.

Expectancy Theory

Expectancy Theory (Lewis 1938; Tolman 1959) is a cognitive theory of motivation in which learning is described as the acquisition of expectancies or a knowledge of what leads to what in the individual's particular environment. This theory suggests that human behavior is a function of a person's beliefs and expectations about how potential actions are related to various outcomes and the value of those outcomes. Two major assumptions essential to this theory are: (1) there exists the perceived probability that the organism can perform an intended behavior and (2) there exists the probability that certain outcomes will result from the intended behavior.

The individual moves toward a clearly apprehended goal with a purpose of attaining it and is knowingly ready

to strive for the goal when circumstances permit. Because the person moves toward a goal, he demonstrates by his behavior that he anticipates a consequence and had acquired the equivalent of a knowledge of relationships. However, it is important to remember and maintain the logical distinction that exists between one's preference for a choice and the actual choice itself.

In more technical terms, learning is described as the acquisition of "sign-gestalts" about the environment. "Sign-gestalts are conceived as having three parts: a sign, a significate, and a behavior-route leading from sign to significate" (Hilgard and Marquis 1961). A sign is the equivalent of an "expectation" and if the person behaves in a certain manner (behavior-route) he will reach the outcome, significate. Learning becomes the ". . . making or the remaking of such expectation sets . . ." (Hilgard and Marquis 1961).

"Learning consists of changing from one systematic, generalized, purposive way of behaving to another until the problem is solved" (Krechevsky 1932). In the process of learning the individual will test and retest and reject a series of "hypotheses" until the correct one is discovered. This particular explanation works more effectively in those situations involving alternative ways of responding as versus situations where outcome possibilities are limited. Krechevsky further breaks the process down into two phases: a presolution period and a solution period.

In abusing alcohol, a person has learned how to deal with his internal and external problems. The abusing behavior is repeated over and over again. A simplistic explanation of the process goes as follows: the individual has an expectation (sign) that the drug alcohol will help him; he obtains the drug and consumes it, and tensions are reduced. His behavior, although systematic, is inappropriate. The hypotheses is incorrect. This would be the presolution period as described by Krechevsky.

For the solution period, it is possible to theorize that a therapeutic contract for no-drinking behavior immediately permits the client to expect an outcome and one that can be valued. Maintaining the contract permits the client to reorganize expectations about the benefits of alcohol as well as movement toward a reorganization of his perceptual field, especially as related to his personality functioning and dynamics.

To explore attitude change and behavior change, it is important to remember that a change in one's attitude does not necessarily guarantee a corresponding overt behavioral change. So perhaps it is possible to change behavior first and then construct the dimensions of how the behavior change can contribute to a change in the attitude one has toward oneself. It is possible to change, to assume new attitudes about oneself, to act differently on one's perception.

Realistic Expectations

The risks of the new behavior before the person must not be beyond the scope of his ability. It is necessary to keep before us the knowledge that the individual seeking help will probably have varied dimensions within the boundaries of his personality and behavior. We see elements of repetitiveness, stereotypy, insatiability, and compulsiveness which create a continually growing cover and barricade to the underlying problem areas. Support for risk-taking must be built into a system that balances both the extrinsic and intrinsic rewards of the learning system. Extrinsic rewards would be the cessation of alcoholic beverages and positive recognition from family, friends, and employer. Intrinsic rewards would be the positive knowledge that one chose not to drink, did not drink, and had the internal strength to be successful in carrying through one's decision. We might see a minimizing of internal tensions, a positive attitude toward self and reality, and ego-reduction of infantile elements within the personality.

Finally, surrender is necessary--the understanding and personal admission that the individual can no longer go on with his current form of self-destructive behavior; one simply has to change.

Self-Perception

A person learns to look upon his behavior from the points of many people. He learns their various points of view at different periods in his life and these views have

varying importance for the organization of one's behavior. These organizations will be used to help learn how the game of life is to be played. The defense structure will represent a collection of skills for achieving goals, either positive or negative. It becomes increasingly clear that in order to understand why people do what they do, and certainly to intervene for change, one must move from exclusive investigation of the inner dynamics and look to the social context within which the individual lives. The prediction of human behavior requires a careful study of the social context within which the individual lives. The prediction of human behavior requires a careful study of the social contexts within which people move, the expectations as to how they will behave and the authority which tells them who they are and what they are supposed to be. People are what you expect them to be, or at least they behave as you expect them to behave.

Expectations of Success or Failure

The child who decides upon and incorporates a life position of "I'm not OK" can be expected to approach life, himself, and others with specific expectations of success or failure. Studies with regard to an individual's expectations of outcome to success or failure tend to confirm these ideas (Baigan 1968; Argyle 1964; Hess and Bradshaw 1970; Locke, Bryan, and Kendall 1968). The child, based upon earlier experiences of reward and punishment (stroking and non-stroking), approaches both standard and novel learning

situations with an expectation of their capability and ability to be either successful or to be a failure.

It is also necessary to both assume and demonstrate that the performance expectation is not simply a function of intelligence quotient, but that it is also a function of a psychological position, and that success or failure is the outcome of one's own efforts. Studies with retarded children (Cromwell 1959; Gardner 1958; Heber 1957) supported the idea that their success or failure was probably colored as a function of their feelings of achievement motivation, feelings of competence, willingness to try new tasks, and attitudes. Blackmen and Kahn (1963) found that expectations of success or failure produce similar effects in normal and mentally retarded subjects. The evidence, however, tends to overwhelmingly support a positive relationship of expectations and success.

Direct research evidence, according to the findings of this writer, is at a minimum. However, some scattered statements do exist. Baigan (1968), in using a case study approach, found that the role of emotional attitudes played an important part and were a major determinant of blockage in the entire learning process. Two major attitudes she found were that these individuals felt they should not be required to struggle for knowledge and are not responsible for the inability to learn and that other individuals have more innate ability to learn than themselves.

In summary of their research, Hess and Bradshaw (1970) support the statements of Baigan. It is their conclusion that the individual's life performance depends on the value of one's self-perception, achievements, and the degree to which he has accomplished his expected goals.

From a theoretical framework, Locke (1969) suggests that the effects of reinforcement on learning may be mediated by a process of goal setting. The statement of a specific goal leads to improved performance. This model supports the transaction position because the individual has in fact worked and is working toward a life position of OK'ness or not OK'ness.

The expectations that one has toward oneself and one's skills play a major part in the success or failure of one's specific performance. These expectations are in part determined as a function of genes, I.Q., motor coordination, physiological progress, capabilities and abilities. In addition, a major determinant is the attitude one assumes toward oneself, one's behavior, one's potential. Telling oneself that one is not capable of performing in a specific area will probably produce behavior or performance that is minimal and reflective of that negative attitude. It seems to be generally assumed that once these decisions are made, they cannot be changed. This does not follow since we are dealing with logical cognitive decision-making and redecision becomes possible.

Relearning

For some, relearning will represent a challenge and new opportunity for development. For others, relearning may well emphasize the stress or dissonance that is already being experienced by the individual. More specifically, as a result of participation within the particular rationale and processes of therapy, the individual's behavior could change.

Because of the alcohol-abuser's history of failure to control one's ingestion of alcohol, it becomes exceedingly important to firmly but gently invite the person to participate in the risk-taking necessary to produce behavior change coupled with attitude change. There now exists the opportunity for a real and consistent relationship in exchange for abstinence from alcohol. Learning to participate in the risk-taking, the problem-solving process is essential. The individual is, after all, the best caretaker of his own learning.

Self-Concept and Learning

There is a growing body of evidence indicating that a direct relationship exists between the individual's self-concept and his observed behavior and perceptions. Self-concept is seen to be related to the [illegible]ds that individuals perceive as necessary to different roles and their ability to meet the demands they perceive being made on them by their various roles.

An individual's self-concept is a functionally limiting and facilitating factor when interwoven with motivation.

Research evidence (Fink 1962; Stephens 1967; Argyle 1964; La Benne 1968) supports a positive relationship between an individual's self-concept as either a limiting or facilitating force. Self-concept is related to how an individual perceives demands as related to specific roles and their individual ability to meet the demands they perceive being made on their various roles.

Few studies, according to the research of this writer, are available that indicate a negative relationship of self-concept to performance. An interesting study by Beijk (1966) did, however, report negative relationship. He reports that the positive and negative expectancy toward a task, when added to a general positive and negative self-concept as an independent variable, is that subjects with a negative self-concept would in general strive for a poorer performance than subjects with a positive self-concept. The assumption was not supported. Subjects with low expectancy tried as hard as those with high expectancy to obtain maximum performance.

It seems appropriate to act "as if" the relationship between self-concept and performance is positive. However, a major dilemma exists in exploring and researching evidence to support these statements and their relationship to each other. In researching the literature on this topic, this writer discovered two problems: (1) use of key words change

according to the discipline approaching the subject and (2) the problem itself is relatively new in importance and seems to date back in history for only ten (10) years.

In regard to the first statement, Psychology uses the key words "Self-Concept," Self-Perception," "Body-Concept." Education does not use "Self-Concept" but rather uses words such as "Self-Adaptation," "Self-Perception," and "Self-Knowledge." It is difficult to evaluate the literature over the past ten (10) years with confidence that the use of these multiple phrases are in fact discussing the same concept. There appears to be no interdisciplinary approach.

Although the concept of "Self-Concept" seems difficult just as a phrase, the problem is further complicated because the topic has received serious consideration for only ten (10) years. That is not to say it had not been previously received but rather that the materials now began to appear with such key words as "Self-Concept," "Self-Perception," etc. The apparent difficulty for serious research appears to be dual. First, to be sure that "Self," approached from various disciplines over the past (10) years, refers to the same variables and phenomena, and second, to discover the key issues of ten to fifteen years ago that accurately reflect what, for example, is being discussed in this paper.

Positive Relationship

Within the structure of a positive relationship, including the positive regard of the therapist toward the client, it is possible for a planned program of change to be developed and acted upon. People help each other, each and every day. Helping and caring relationships range from the simple providing of a needed service, such as selling someone a daily newspaper on a street corner, the delivery of a newborn baby, a heart transplant, a government election, to the personal development that occurs as the result of a committed interpersonal relationship. The world exists in relationships--earth to space, stars to space, stars to planets, sun to planets, man to man, doctor to patient, earth to food, money to government, church to God, church to people, man to God, wolf to the buffalo, water to plants, and so on . . . .

Assuming the responsibility of defining oneself as a therapist, one announces that there is the belief and willingness on the part of the individual to assist other individuals in changing their behavior or attitudes toward themselves. A person, by becoming a therapist, says that he is willing to enter into a unique relationship in which he will assist another individual in repairing the relationship he has with himself and with an expectation of some change in his life theme patterns and/or personality structure. The therapist is also saying that he believes and is motivated to respond to the requirements of the role of a

therapist. Underlying these assumptions on the part of the therapist is the understanding that one (the therapist) is motivated to meet the established criteria for functioning in that occupational role. Second, and certainly more complex, are the conscious and unconscious motivations of the individual that he would seek to participate in this particular occupation. And finally, is the belief that there are benefits to be obtained when one person offers to help another person, within a relationship, to achieve some goals.

Next is the therapist's attitude and concept of change. Not only the professional, theoretical, and philosophical position, but also the personal beliefs that the therapist embraces as simply another human being in the journey of life. As an agent of planned change, the therapist must have a broad perspective of belief, both theoretical and practical, toward capacity for change by an individual. Hope that change can occur is an important dimension. In moving toward change, the therapist is bound by a security orientation and/or a need to see the world in a highly prescribed set of behavioral patterns. In addition, the therapist must be able to determine if the change that the individual is seeking is realistic and possible. Finally, it is also important that the therapist not attempt to make the individual over into more than is being requested.

How much change does the therapist believe is possible, and what is the source of his particular attitude

toward change--are they personal or primarily theoretical? What risks to change have characterized the personal life theme and patterns of the therapist? How does he handle change and its ramifications?

Another area is the effect of changing one attitude or pattern of behavior and the resulting tension or conflict that change may produce in another area of the person's personality or functioning. Similar to repairing a car--a change in one system frequently effects the functioning of another system.

The approach to intervention for change requires a complex set of operational techniques applied to the process of therapy. Are the techniques applied to a rigid model strategy or are they adjusted in the humanness of a caring relationship? Is the system the "thing" that creates the change or is it the system, supported by the caring human consciousness of the therapist--when he encounters the conditions of human possibility, that causes change to occur? These questions are difficult to answer, for no single answer or research evidence exists to support either system. One question in this area leads to another and another. It is therefore critically important for a therapist to consider carefully any request for change, the possibility of change, a strategy for change, and his capabilities to assist in the process. And, finally, we need to consider the risk and the cost of risk to change behavior. Is the cost reasonable, appropriate, and affordable by the person

seeking change and, if the risk is taken, will the desired change occur? At the other extreme, what damages will be incurred if no risk to change is undertaken, and if change as hoped for does not occur, what happens to the individual when confronted with the future and the possibility of change. Simply stated, the therapist as an agent of change must possess a vast and broad perspective of the phenomena called CHANGE.

All therapeutic models have stated goals for outcome of treatment and, within the language framework of that system, define the nature and dimensions of change within the treatment program. Although each modality of treatment will have a stated system of strategy, it is probably more important to remember that each model or system has several common essential ingredients. A client and a therapist have a specifically defined, unique relationship in which: (1) some area of changed behavior is necessary for the client, (2) hope and expectation for change exist, (3) there is possibility for change, (4) there exists for that system a body of theoretical knowledge that, utilized in intervention, will assist in the process of change, and finally, (5) the client comes for treatment, improves, is able to manage one's own life in an improved way, and leaves therapy better able to care for oneself.

There is an elaborately prescribed body of knowledge, education, skills, professional recognition, and license procedures that are considered necessary and mandatory for one to possess if one wishes to enter into a helping

relationship with others, specifically defined as treatment or therapy. Behind these preparations is the assumption that this knowledge will assist in the process of change and the preparation of individuals to be therapists is enhanced by acquiring the knowledge of change to be used within the therapeutic relationship. And yet, this assumption is questionable since evidence exists to demonstrate that several areas of relationships within our social systems do not require this type of preparation. Two examples of helping relationships that do not require the similar educational or training requirements are: marriage and parenting. We can speculate that there exists the recognition that society knows that somehow errors in earlier relationships, including genetic programming, that contribute to the individual's ineffective behavior, need to be corrected. But the systems and the individual providing the correction must be more carefully defined in order to effectively assist the individual in discovering and participating in changed behavior. Change cannot be left to chance.

No discussion would be complete without reference to the fact that there is also an economic motivation on the part of the therapist. He is simply saying that he has certain skills in effecting change, and these skills and services can be obtained for a financial consideration on the part of the patient.

The interpersonal self-fulfilling prophecies of a therapist has a major influence on the outcome of treatment.

Leake and King (1977) state that ". . . the effect of such prophecies has been observed to be a variant of the same general principle: that in the interaction between two or more persons, one person's expectation for the behavior of another can come to be self-fulfilling." Other researchers are Clark (1965), who has reported that the success in learning of blacks from ghettos was based on the white, dominant group's belief that they could be successful, Rosenthal (1961) and Jacobson (1968), who have shown that teachers' expectations had positive effects on underprivileged children's development, King (1974), who indicates that managers' expectations have a significant impact on workers' productivity, and Carrell (1978), who found that the staff members optimism and personal commitment played a major role in the patients' recovery.

Change in Terms of Human Behavior

The individual, created biologically, arrives in the world with a particular set of genetic materials into a defined social system, geographically located, with potential for participation in a process of development which is dynamic and extends from birth to death. The developmental process is prescribed sometimes by genetic programming and sometimes by rules established by man and his society. At the very foundation of this process, and an integral part of the process, is a phenomena--CHANGE.

Individuals proceed from one phase of development to another within the boundary of prescribed order and the

given expectation that the movement is normal, reasonable and appropriate. The number of developmental areas increases and becomes more complex as the individual areas increase in number and becomes more complex as the individual goes from age to age, level to level, and skill to skill. Developmental behavioral areas include physical, mental, spiritual, intellectual, social, emotional, educational, and attitudinal. Each of the areas has a prescribed and dictated nature with a predictable onset, history, phases, and dimensions. From the beginning, new information and data are added to the area and followed by the addition of more information and new data. The process is continuous. In addition to the unique development and expansion of each individual area, there is also the fact that each area had to be integrated with each other; no area functions in isolation from another. Although we are talking of the dynamic development of the individual both internally and externally, we must also remember that people, places, rules, and institutions have an impact on the process of developmental change and integration experienced by the individual. Change occurs as a natural, dynamic developmental process. However, the process is frequently confronted with interventions of all sorts designed to help the individual proceed from one level of development to another. It is a continuous process.

So far, we have been discussing "normal development," yet five problems that can interfere with the processes mentioned are:

1. Initially we said the newborn arrives thru biology with genetic materials. The process begins here. Yet, if the infant arrives with no eyes, his process of development, although normal for him, will not be normal within the definition that would apply to the larger, average population.

2. Positive extreme acceleration in development in one area and its effect upon other areas of development. For example, a twelve-year-old, ready to attend college, may have the intellectual development for that experience, but not the social skills for relationships encountered in college social life. Or a thirteen-year-old, fully developed female may have all the physical capabilities for sexual behavior but be lacking in emotional reaction and adult responsibility.

3. Reduced intellectual capabilities in a society that is highly verbal, reasoning, and moving toward some form of advanced intellectual development, with a reduction in occupational opportunities that require minimal intellectual development, with a reduction in occupational opportunities that require minimal intellectual skills.

4. An individual that begins developing normally but, due to some trauma to their system, loses use of a particular faculty.

5. The reduced or restricted development that occurs as the result of people interacting with others and the negative life theme messages passed on.

Intervention for Change

Intervention for change within the therapeutic relationship is a standard part of the process.

Here we are discussing information that an individual receives about himself and his behavior from the therapist in the process of searching for changed behavior. What effect will positive or negative information have on the client in terms of the willingness to continue to learn and participate in the therapy process? Change is defined as an alteraction in a structure, a process or an event, an observed difference in a given perception with the passage of time.

The presentation of intervention information to the client about himself is an ongoing process that begins with the initial contact of the client with the therapist. Initially, and as the relationship develops, it is important to remember that the process of change requires the trust and dependency found within the therapeutic relationship. As the relationship grows and the work becomes deeper and as more difficult conflicts surface, the timing of intervention support becomes more critical. Information given too early may cause the client to quit therapy, and information given too late may not contribute to the relearning process.

The process of change involves presentation of materials by the client, elaboration of such materials, clarification of materials, and confrontation of impasse (sometimes called sick point). At this point one of two things happens. The client goes past the impasse to begin exploring more information and to see how inappropriately things have been put together, or blocks and refuses to go on. At this point the therapist decides to either push at the impasse or permits the client to go back to Stage I (presentation of materials) and the process begins again. The therapist needs to appropriately, with effective timing, confront the client, help the client tear apart information, knowledge, assumptions, provide support, reward and reinforce, all within the operational process of functional perception of reality as it is, rather than a perception of reality that is predicated on incomplete or inaccurate knowledge, emotional fears, or life themes decided upon too early in the client's developmental process.

The knowledge imparted and reinforced by the therapist will have two positive rewarding effects: (1) reward and reinforcement that occurs within the therapeutic environment, and (2) rewards and reinforcement that occurs as the result of new behavior in the client's daily world.

Treatment of a Symptom

The direct treatment of a symptom for a disease or illness is deeply rooted in the history of man treating man. When inviting the individuals to direct treatment, two

factors must be considered. First, there is precedence for this form of treatment approach. Patients take medication prescribed by their doctors, and people submit to surgery for the removal of an organ or tissue. Second, the therapist is asking the patient to immediately eliminate from his system a drug that has objectively been causing harm to his physical, mental, and social well-being.

In directly treating the symptom of alcohol-abuse, the therapist must be careful to avoid the danger that the individual may see the therapist as depriving him of something valuable. Individuals seeking help are caught between the use of a drug which reduces or eliminates the tensions and conflicts related to their problem(s) and the struggle to stop introducing the drug into their bodies.

Coven and Blackhawk (1978) in discussing Perls states that he believes:

> Learning is permission to try out and discover. Further, a gestalt principle is not to be told constantly about things but to experience and do, which involves more of the person's being and behavior.

In gestalt treatment, an "experiment" is permission to try out and discover. In Transactional analysis, the contract is the vehicle through which the therapist gives permission to the patient to try out some form of new behavior; an opportunity to do.

In treating an alcohol-abuser, Zechnich (1969) states that alcoholics are "heavily involved with a fear of the success syndrome." Their behavior is toward the avoidance of success. By producing a symptom cure, the individual

immediately experiences success of his behavior, and the success at this decision to change his behavior, and he is given more time to follow these with indepth exploration of his conflicts. Cottington, Groder, and Zechnich (1969) state that "Anyone who sticks to treatment for three months will experience a symptom cure but a script cure takes one or two years." Since the symptom cure can be accomplished in three months, the door would then be open for a deeper cure."

Most TA theorists, expecially Steiner (1966, 1967, 1969), agree that alcoholism and drug abuse are deep human tissue issues for people with self-destructive scripts. Drug abuse is seen specifically as a self-destructive disorder. There are two types of scripts, harmatic and non-harmatic. People who abuse alcohol are believed to have life scripts that are harmatic. Berne believed that there were no such individuals as "alcoholics" but rather, he saw a population of individuals who abuse alcohol and were living out their harmatic scripts. Harmatic scripts are tragic and have, according to Aristotle, three characteristics: a prologue, a climax, and a catastrophe. "Harmatic individuals play hard games involving human tissue. Harmatic scripts, like all scripts, are the result of parental injunctions" (Steiner 1967). There are individuals with harmatic scripts involving destruction of human tissue through excessive ingestion of alcohol, and individuals with non-harmatic scripts who play for depression, anger, and guilt. The former group is seen as moving toward suicide, while the

latter group is generally seen as going nowhere with their life course. In both, the course is toward some expression of self-destructive behavior. Both maintain an essential life posture of I'm not OK.

> Treating the alcoholic is similar to treating persons with other psychological problems, with this one exception: the symptomatic complaint must be eliminated before the emotional and personal problems can be successfully treated. Continued drinking while in treatment reinforces the addiction, complicates the already existing problems and interferes with the learning which must take place if psychotherapy is to be effective (Kepner 1964).

The general effect of alcohol as a drug is to reduce or prevent one from thinking. People who abuse alcohol receive messages from the forces of society within their head (Superego) through internal dialogue to the unmanaged impulses (Id). These messages give permission and incouragement to drink for the purpose of reducing the unmanaged impulses or directives that state that the only way to feel calm and avoid the pain of these impulses is to drink oneself into unconsciousness. In Transactional Analysis terms, "Alcohol and other 'downers' probably have a primary effect in reducing the influences of the Critical Parent thus reducing Parent-Child ego state hassles and freeing up Child energy (relaxation, euphoria, anger, silliness, sexiness" (D'Andrea 1977). As drinking continues, autonomous functioning is reduced and consciousness is reduced.

As a result of the circular dialogue that exists within the individual, the alcohol-abuser appears unable to move toward autonomy (Ego) in decision-making or turn-on of the Adult ego state. In the treatment of the person who

abuses alcohol, the therapist wants to give the client permission coupled with strong supportive reality statements that: (1) break the internal dialogue that goes on between the conflicting forces within the client's head, (2) interrupts drinking behavior, (3) encourages thinking and reality testing, (4) demonstrates to the client his power to control and manage their drinking behavior, and (5) uses time to encourage the development of new life themes.

Ego Reduction

The achievement of goals other than total permanent abstinence is necessary for complete rehabilitation to occur. "The goal of every program should be to help the alcohol-dependent patient learn to deal effectively with his life problems without using the drug and to adapt to his environment in a reasonably mature manner." (AMA 1968).

Ego reduction refers to the process in which: (1) the original ego is brought back down to earth and permanently kept there, (2) the ego announces that it is no longer supreme, (3) surrender involves both the conscious and unconscious, (4) there will be freedom to live within reality oriented limitations and boundaries, and (5) goals of treatment include symptom reduction, dealing with one's life more effectively, and a sense of inner harmony and serenity.

In discussing alcoholism and surrender as related to ego reduction, Tiebout (1961) presents four (4) distinct stages in the reduction process: (1) the need to hit bottom-existential despair, (2) the need to be humble--I am simply

a human being, (3) the need to surrender--I can't go on this way, I need to change, and (4) the need for the primary ego to be reduced.

It is the ego that has to become humble, and yet, it is important to understand what occurs in the unconscious during the process of ego reduction. In submission an individual accepts reality consciously, but not unconsciously, with submission which is superficial; tensions continue. Whereas, when there is the ability to accept reality on the unconscious level, conflicts are reduced or eliminated, and an inner harmony and freedom follow. The greater this internal relaxation, the greater is the inner acceptance of reality. "Unless the unconscious has within it the capacity to accept, the conscious mind can only tell itself that it should accept, but by doing it cannot bring about acceptance in the unconscious which continues with its own non-accepting and resenting attitudes" (Tiebout 1953). The acceptance of reality by the unconscious produces a deep unconscious shift in attitude and the replacement of the old ego with new activities.

Finally, Tiebout (1949) in summarizing his works on the act of surrender notes five (5) major points: (1) surrender is an unconscious event that occurs when certain traits in the unconscious mind become involved in a certain set of circumstances, (2) it is the act of surrender that invites the switch from negative to positive, (3) the positive phase is a state of surrender that follows the act of

surrender, (4) the act of surrender and the change that follows are inseparable, and it is safe to assume that if there is no change, there has been no surrender, and (5) the state of surrender, if maintained, supplies an emotional tone to all thinking and feeling that does insure improvement.

An important event occurring in the process of ego reduction is the phenomena of surrender. Tiebout (1961), in discussing the notion of surrender, wrote:

> The existentialists, when they advocate being oneself, advise one to let go and be. They view surrender as a letting go of control and presume that such dropping of rein will permit greater spontaneity and naturalness and a greater sense of being a person.

One accepts the idea that one is simply just a human being. A surrender experience reduces the individual's ego and permits more realistic functioning. The old ego has lost its grip.

Freud saw therapy as a running battle between the original narcissism of the Infant (ego), "His Majesty-The Baby," and the therapist whose task it was to reduce the original state to more manageable proportions. There can be no successful compromise with the ego. The Ego is made up of the persisting elements in the Adult Psyche of the original of the child. When these infantile traits continue into adulthood, we see the individual producing immature and exaggerated responses to reality.

Freud conceived the ego as an emergent from the id as the id was modified. It is manifested by an individual's

capacity to think, reason, exercise his will, and having a central focus around which these faculties become organized. Viewed this way, the ego is perceived as a control mechanism. This is contrasted with the person said to have a "Big Ego" in which one thinks especially well of himself, is arrogant, stubborn, impatient, head strong, prideful, and could be labeled egotistical. The big ego is seen as a narcissistic remnant of the infantile state. Freud (1925) states that the "Development of the ego consists in a departure from the primary narcissism and results in a vigorous attempt to defend it." It is within the movement from a position of exaggerated ego reference to a position of modest self-evaluation that an individual becomes more humble. It is the reduction of the ego which makes sobriety possible and the reduction of narcissistic components that moves one toward ego maturity and realistic functioning.

Berne (1961) in discussing treatment of the total personality and the subjective need for inner harmony states that behaviorally the individual must balance the Parent-Adult-Child states where all agree that new learning can occur by selecting activities wherein the concerted efforts of all three ego states are appropriately directed so as to give universal satisfaction. "In other words, he learns to accept as Adult only what was completely rational, in the sense of psychologically and materially realistic, in his judgment of his environment and the probable effect of his behavior upon it" (Berne 1961).

Contractual Treatment

Contractual treatment is a method of therapy in which the client states ". . . what he wants to be cured of in specific behavioral terms" (Steiner 1972). As Schwitzgebal (1975) points out, "Contracts that make explicit the goals, methods, risks and benefits of treatment provide an opportunity for self-determination by the patient that is in marked contrast to that in which the patient merely consents to treatment without clear specification of expected results." Contracts provide the client with an informed process of commitment to behavioral goals. Further, they provide operating guidelines in which the client and therapist can relate to each other. The individual makes and is responsible for his decisions as to how he will live in the world. He has to do his own work, especially in defining goals. By saying "wants" from another person, the client displaces responsibility for action. By electing to use the contract, the client chooses, in this situation, non-drinking behavior. With the non-critical attention of the therapist, the client can be guided and assisted in defining and agreeing to behavioral contracts.

Contracts as a tool permits an individual to interrupt a self-destructive life theme and move toward a change in behavior. According to Gelbert and Wilson (1977)

> The acceptance of a contract that the client can do in the here and now, or immediate future, enhances the chances of success. Both Minor and Intermediate contracts involve to some degree substitute goals.

Life theme redecisions require major contracts and will involve feelings and behavior change without limitations. Success will be judged by the client, based on one's own internal ego structure and levels of aspiration.

The use of the contract as a positive adjunct within the therapeutic process has been demonstrated by various researchers: Vannicelli (1979), Haykin (1977), Meeks (1976), Cassady (1975), Cohen (1976), Ross (1974), Stern (1974), and Miller (1972). Few empirical studies exist that demonstrate the positiveness of an explicit treatment contract. However, the works of Korman (1972), Brown (1972), Giles (1970), and Lawson and May (1970) do provide positive results on the use of the contract as a therapeutic aid.

Individuals make and are responsible for their decisions as to how they will live in the world. Because of this individual responsibility, it is important to concentrate on what the client is saying now, what problems they have, and leave the choice of ever changing goals to them. It follows that within the therapeutic relationship the client be taught a process rather than an attitude toward life. Discuss whatever the individual chooses to discuss and together the client and the therapist will work out something important, the limits, nature, and conditions of human possibility. The client's current problem(s) and issue(s) reflect a growth, restricted in its original natural development by deflections incident to faulty responses to early crises, blocked or suppressed emotions, especially rage or anger having followed unmanageable, unendurable situations.

Goal Setting

Therapy contracts represent a method of goal setting. Kurt Lewin (1935) theorized "that need or want in a person created a system of psychological tension that would be discharged when the need or want was met." The setting of a goal, therefore, establishes tensions that will be discharged when the goal is achieved.

The reduction of tensions in the ego can produce an inner calmness that contributes positively to a person's life. With the elimination or reduction of tension, it no longer becomes necessary to reduce these tensions with exaggerated and inappropriate defense mechanism. An individual potentially becomes capable of seeing his internal tensions as exaggerated and inappropriate defense mechanisms. An individual can become capable of seeing his internal tensions from a variety of new perspectives: (1) a need to expand his psychic space and boundary, (2) a need to renegotiate or recycle energy which is related to practical issues either external or internal to that person, or (3) a statement that, at some level of consciousness, some aspect of his behavior needs reviewing. Individuals on a repeated basis begin to increase their expectations of personal success.

The vehicle for promoting this success is the contract. Just as the alcohol-abuse problem did not appear spontaneously, so the control and reorganization of behavior does not occur spontaneously or by childlike wishes. There

must be the establishment of a process. The individual, in agreeing to accept a contract, believes that behind this vehicle there exists some crystallized knowledge which will provide some form of protection and security while movement from one position to another is undertaken. The possibility and prediction of success based on new levels of aspiration and goal-direction must be reasonable in terms of individual human possibility. The contract can be used to interrupt drinking behavior. It further provides the individual with a system in which he can confront his particular internal tensions and control his drinking behavior while he explores and investigates the nature and dimensions of his defensive childlike behavior.

Contract Elements

Contracts, according to Steiner (1972), must meet four basic requirements before treatment can begin:

1. Mutual Consent. An offer of treatment is made by the therapist followed by a client's acceptance. However, before an offer can be made by the therapist, he must have a request for help by the client, a detailed understudy of the client's past history, specific and clear statements as to the outcome of treatment, and finally an acceptance of treatment by the client.

2. Valid Consideration. The person seeking help agrees before treatment to confer benefits on the therapist. Specifically, the benefit intent on the part of the therapist in this study is an attempt to remedy an individual's

abuse of alcohol. In return the client agrees to confer the benefit of a nominal dollar sum to the therapist.

3. Competency. Contracts can only be agreed upon when both parties are individually capable of entering into and acting upon the stated terms of the contract. This, therefore, excludes minors, incompetent individuals, and intoxicated persons.

4. Lawful Object. Contracts must not be in violation of the law or against public policy or morals.

The objectives of contractual treatment in the area of knowledge are cognitive, in the area of values, affective, and in the area of skills, psychomotor. So a client presents himself for treatment to alleviate his abuse of alcohol, and enters into contractual treatment to alleviate his abuse of alcohol.

Contract Renewal

By renewal of the contract on a regular weekly basis, there will be the establishment of a process which will elicit a response and have a regular schedule of reinforcement. Reinforcement will be both an internal and external precess. Each time the person chooses not to drink, and does not drink, the individual is able to confront internal tensions and not have to discharge those tensions defensively or with inappropriate behavior. Externally, as the person reports success in not drinking, the person receives positive stroking from those around him. This process is repeated with a regular reinforcement schedule in effect and operating

each time the person wants a drink but chooses not to drink and does not drink. The repeated cycle is positive.

By accepting a no-drinking behavior contract, one will be directly treating one symptom of the problem. Because of the contract, behavioral changes will include complete cessation or a significant reduction of alcohol ingestion. The successful matching of one's attitude of wanting to stop drinking, coupled with the successful behavior of not drinking, leads one to anticipate an improvement of the individual's private expectations that the problem of alcohol-abuse can be managed and controlled and provide for the possibility of generalizing positive personal controls to other areas of one's life.

Purpose of the Study

The purpose of this research was to investigate the effectiveness of a subject's acceptance of a non-drinking behavioral contract, within the therapeutic process, for changing the subject's alcohol intake pattern. Approaching the idea that a symptom in this study, alcohol-abuse, could be confronted directly and eliminated in order to reduce the effect of a drug in the body and its effect on the central nervous system, especially as it relates to psychotherapy, memory, and learning.

To evaluate the contract effects as a treatment tool by seeing if this tool is effective in the start of treatment. One positive effect could be the reduction of the reduction of the high-drop out rate that we see occurring

in other situations, such as A.A. This study was not designed to compare the contract with other types of treatment.

Hypothesis

For subjects in individual therapy accepting a no-drinking behavioral contract, there will be positive changes in their patterns of alcohol ingestion.

There will be positive changes in everyday life patterns and interpersonal relationships as a result of positive changes in patterns of alcohol ingestion.

Importance of the Study

This writer has not found any research in the literature dealing with these research problems. It appears that the theories related to therapeutic contracts are primarily based on influential statements of philosophy and reasoning, and are not verified by the methodology of experimentation. This proposal represents a first experimental design.

From a humanistic viewpoint, any efforts toward the discovery of a system(s) that will assist in the alleviation of human pain is to be sought after. Seeing people move from a position of unsuccessful patterns of behavior to a positive health and improved behavior is a desired goal. This study will contribute to that objective.

Demonstrating that contractual therapy is a valid concept opens the door to further inquiry into this treatment variable for additional research. It is hoped that other researchers, encouraged by this initial effort and

the results of this research project, will be interested in exploring the realities of the contract not only in the treatment of alcohol-abuse but also in other areas such as relationship contracts, employment contracts, social contracts, and contracts made by the individual with himself for planned developmental change.

TABLE 1

RATES OF PROBLEM DRINKING AMONG U.S. DRINKERS, BY DRINKING POPULATION, 1973-1975

	Percentages for Each Survey			
	Mar. 1973	Jan. 1974	Jan. 1975	June 1975
All Drinkers				
No problems	64	70	65	63
Potential problems[1]	26	24	24	26
Problem drinkers[2]	11	6	10	10
Males				
No problems	57	66	62	57
Potential problems[1]	29	27	23	31
Problem drinkers[2]	14	8	15	13
Females				
No problems	74	77	70	73
Potential problems[1]	21	19	27	21
Problem drinkers[2]	5	4	3	6

Source: Paula Johnson, David Armor, Susan Polich, and Harriet Stambul, U.S. adult drinking practices: time trends, social correlates, and sex roles. Draft report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0020. July,1977.

[1]A potential problem drinker experienced two or three of sixteen problem drinking symptoms frequently or four to seven symptoms sometimes.

[2]A problem drinker experienced four or more of sixteen problem drinking symptoms frequently or eight or more symptoms sometimes.

TABLE 2

ESTIMATED DEATHS RELATED TO ALCOHOL
IN THE UNITED STATES, 1975

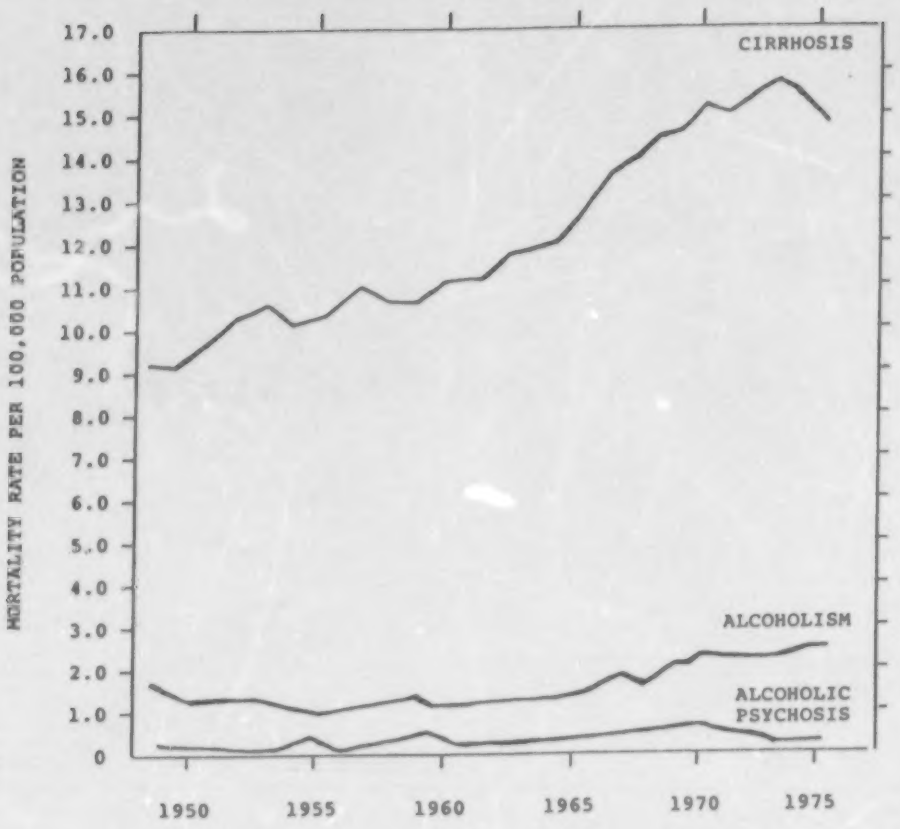
Cause of Death	Number of Deaths, 1975	Percent Related to Alcohol	Estimated Number Related to Alcohol
Alcohol as a direct cause			
Alcoholism	4,897	100	4,897
Alcoholic psychosis	356	100	356
Cirrhosis	31,623	41-95	12,965-30,042
Total	36,876	.....	18,218-35,295
Alcohol as an indirect cause			
Accidents			
Motor vehicle	45,853	30-50	13,756-22,926
Falls	14,896	44.4	6,614
Fires	6,071	25.9	1,572
Other*	33,026	11.1	3,666
Homicides	21,310	49-70	10,442-14,917
Suicides	27,063	25-37	6,766-10,013
Total	148,219	29-40	42,816-59,708
Overall Total	185,095	.....	61,034-95,003

Source: Data from Nancy Day, Alcohol and Mortality. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-76-10 (P). January, 1977, and National Center for Health Statistics, Vital Statistics of the United States, 1972, Vol. II: Washington, D.C.: U.S. Government Printing Office, 1975.

*Includes all accidents not listed above but excludes accidents incurred in medical and surgical procedures.

ILLUSTRATION 1

TRENDS IN SELECTED MORTALITY RATES
IN THE U.S., 1949-1975



SOURCE: Data from National Center for Health Statistics, Vital Statistics of the United States, 1949-75. Washington, D.C.: U.S. Government Printing Office, 1975.

TABLE 3

ECONOMIC COSTS OF ALCOHOL MISUSE AND ALCOHOLISM IN THE UNITED STATES, 1975

Item	Cost (billion $)
Lost production	$19.64
Health and medical	12.74
Motor vehicle accidents	5.14
Violent crime	2.86
Social responses	1.94
Fire losses	0.43
Total	$42.75

SOURCE: Ralph Berry, James Boland, Charles Smart, and James Kanak, The Economic Costs of Alcohol Abuse and Alcoholism--1975. Report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0016. 1977

ILLUSTRATION 2

TRENDS IN PER CAPITA ETHANOL CONSUMPTION IN U.S. GALLONS, BASED ON BEVERAGE SALES IN EACH MAJOR BEVERAGE CLASS IN THE UNITED STATES, 1946-76

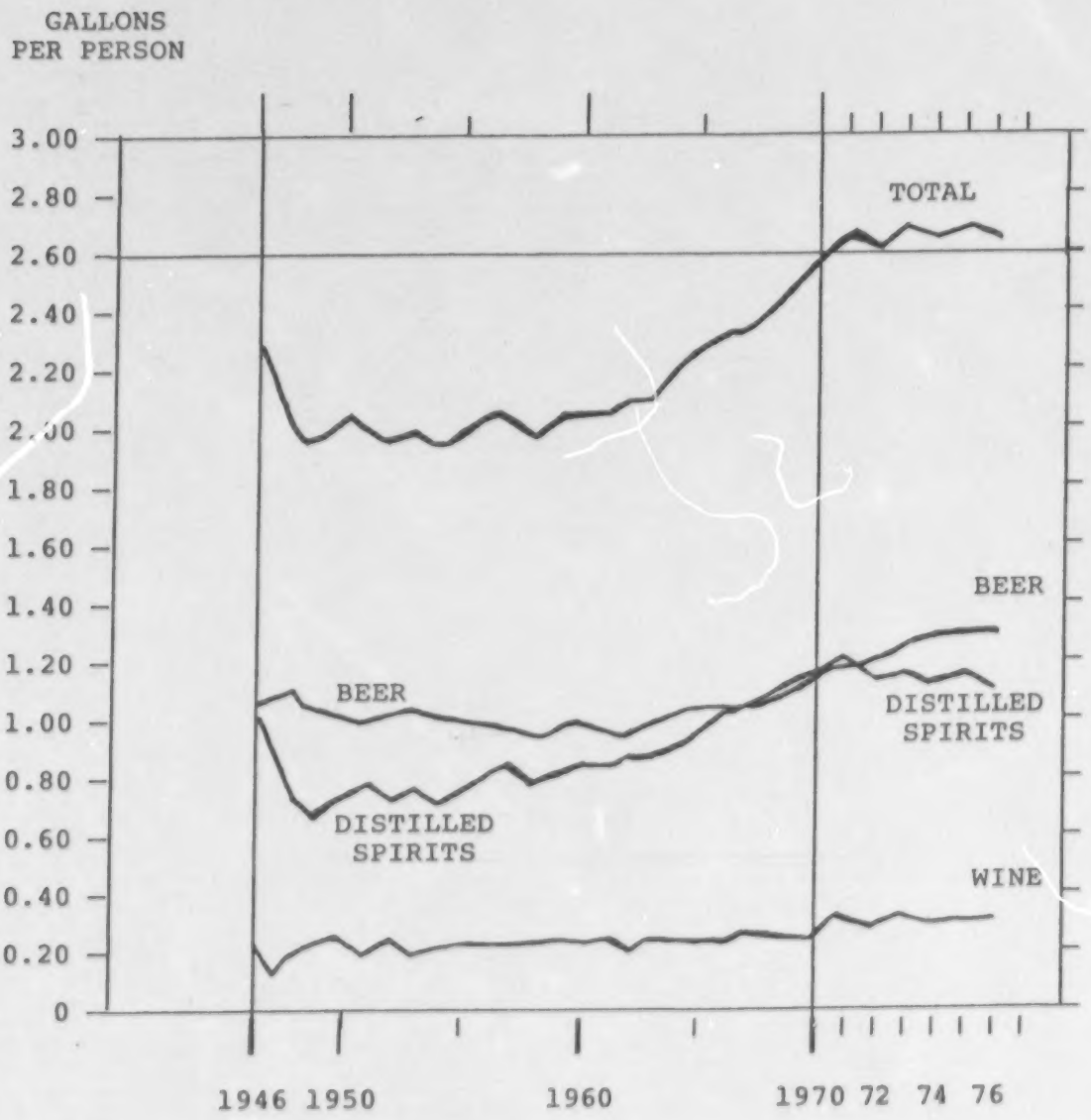


TABLE 4

TRENDS IN ALCOHOL CONSUMPTION, 1971-1976

Type of Drinker	Percentage in Each Drinking Category							6 Yr. Average	Amount Consumed*
	1971	1972	1973 Spring	1973 Fall	1974	1975	1976		
Abstainer	36	36	34	37	33	36	33	35	Drinks less than once a year or never
Lighter	34	32	29	30	28	31	38	32	One drink a year up to 3 drinks/week or 12 drinks/month
Moderate	20	23	23	21	28	21	19	22	2 to 13 drinks/week or 13 to 58 drinks/month
Heavier	10	10	14	11	11	12	10	11	2 or more drinks/day or 14 or more drinks/week
(N)	(2,195)	(1,544)	(1,588)	(1,603)	(1,578)	(1,071)	(2,510)	(12,090)	

SOURCE: Paula Johnson, David Armor, Susan Polich, and Harriet Stambul. U.S. adult drinking practices: time trends, social correlates, and sex roles. Draft report prepared for National Institute on Alcoholism under Contract No. ADM 281-76-0020. July, 1977.

*A drink is the equivalent of one 12-oz. can of beer, one 4-oz. glass of wine, or one 1-oz. shot of distilled spirits, each of which contains approximately ½ oz. of ethanol.

CHAPTER II

DESIGN AND METHOD

Overview of the Study

This study was designed to evaluate the effectiveness of the contract as a tool within the therapeutic process to eliminate alcohol ingestion at the start of treatment and thereby changing an individual's pattern from alcohol abuse to abstinence. In addition, there was the expectation that the Ss would also experience positive changes in everyday life patterns and interpersonal relations as a result of the elimination of alcohol as a defense and escape mechanism.

The Ss were administered three (3) tests: Cage Questions, Michigan Alcoholism Screening Test, Shostrom Personal Orientation Inventory, and completed a Personal History Questionnaire on a pre- and post-test schedule. Scores on these three (3) tests formed the measured dependent variables while the independent variables were the Group assignment of Ss and the time of measurement; that is, pre- and post-treatment. Being a repeated measurement experiment, each subject served as his own control.

This investigation aimed at experimentally testing the theoretical statements of Stiener, who stated that it was possible to effect with the contract a symptom cure in three (3) months. Personality or script changes would require at least one (1) year in treatment.

Definition of Terms

Abuse: To use wrongly or improperly. To maltreat. A corrupt practice or custom.

Alcohol: Any of a series of related organic compounds having the general formula C_2H_5OH. Exhanol. Intoxicating liquor containing alcohol.

Behavior: A response, or response collectively. How a person thinks, feels, and acts.

Change: Any alteration in a structure, a process, or an event. An observed difference in a given perception with the passage of time.

Contract: An enforceable agreement; covenant. To enter into or establish by contract.

Intervention: An action by a therapist that tends to direct or influence the client's behavior during or after a therapy session.

Transactional Analysis: A theory of personality based on the study of specific ego states. A system of psychotherapy based on the analysis of transactions and chains of transactions as they actually occur during treatment sessions.

Description of the Sample

From a population of people who had a current history of alcohol-abuse in northern DuPage County and southern DuPage County (Appendix 1), a total of fifteen (15) subjects were selected and randomly assigned to individual therapy sessions.

Subjects were sought through a newspaper advertising campaign (Appendix 2) that was conducted for two weeks in early December. At the same time, there was a direct-mail campaign (Appendix 3) to Alcoholics Anonymous, Al-Anon, Mental Health Department, hospitals, de-tox centers, former clients, community and church counseling centers, alcoholic clinics (rehab centers), Half-Way Houses, and current clients.

Subjects

All of the S_s who participated in this study were individuals who were currently abusing alcohol, and had a past history of alcohol-abuse. Subjects were from nothern and southern DuPage County.

Selection of these subjects was on the basis of their socio-economic status, age, education, sex, and race. The socio-economic level was set at the middle-class. This was determined from information obtained from the Personal History Questionnaire. There were three (3) females and six (6) males. All were Caucasian. Age and education were matched (Table 6).

There were two (2) reasons for controlling the social and economic position of the subjects: (1) to keep the groups as homogeneous as possible, and (2) because of their positive participation in the roles and responsibilities of middle-class life, these individuals agreed to commit themselves to change, having a greater environmental support for initiating and sustaining abstinence.

Initially, eight (8) subjects were assigned to Group I and seven (7) subjects were assigned to Group II. As a result of four (4) subjects dropping out of Group I and two (2) subjects dropping out of Group II, Group III was formed with six (6) subjects for statistical analysis purposes.

Procedure

Each subject completed a Personal History Questionnaire adapted from B. McCall Index (1956) (Appendix 4), The Shostrom Personal Orientation Inventory (POI) (1964), Cage Questions (1974), and the Michigan Alcoholism Screening Test (MAST) (1975) (Appendix 5). Tests were administered before the beginning of therapy.

Personal History Questionnaire was used to gather data used for matching subjects and determining patterns of behavior, age, sex, educational experiences, family history, income, employment and earning history, counseling or therapy experiences, drinking and drug pattern history, and social activities.

Shostrom Personal Orientation Inventory (POI) was used to measure attitudes and values one has toward oneself as a self-actualized person. A self-actualized person is one who is more fully functioning and who lives a more enriched life. Scales include measurements in the following areas: valuing, feeling, self-perception, synergistic awareness, and interpersonal sensitivity. It is generally agreed that a self-actualizing person would be a desired result of psychotherapy.

Cage Questions is a four (4) item test designed to serve as an initial screening device for the identification of persons with alcoholic problems.

Michigan Alcoholism Screening Test (MAST) is a twenty-five (25) item test developed to identify alcoholics.

Total testing time varied, but the average time was approximately two (2) hours. The POI, CQ, and MAST are paper and pencil tests.

Using a table of random numbers, seven (7) subjects were assigned to Group I, and eight (8) subjects were assigned to Group II. The two therapists were randomly assigned to Groups I and II.

Each subject had a total of eleven (11) therapy sessions. There was also one pre-testing and one post-testing session. The first therapy session was primarily used for contract work. Individual therapy sessions lasted for forty-five (45) minutes.

Each session included a review of the contract: behavioral results, discussion of the client's attitudes and feelings about their behavior, and contract renewal. Contracts were renewed from session to session. All contracts included a time limit (week to week), and a behavior response that could be measured (days without a drink). All contracts were signed on a weekly basis (Appendix 6).

Post-testing included the POI, MAST, Cage Questions, and Personal History Questionnaire, sections of Drug and Drinking Patterns, Employment History, and Social Activities.

Instrumentation

A Personal History Questionnaire was completed by each subject and the data was used to classify each subject for socio-economic level, age, sex, marital status, educational experiences, drug pattern history, and social activities.

The Cage Questionnaire was developed in 1974 as a screening device for the detection of alcoholism. Mayfield, et al, found over a one-year period that a two or three item positive response is the criterion for diagnosis, a positive diagnosis was made 89 percent of the time.

In an effort to assist the courts in the identification of problem drinkers, a self-administered questionnaire was developed (Mortimer, at al, 1973). This tool consisted of items requiring true-false responses. The instrument developed had a high internal consistency reliability .95 and .94 and for validity of test an .85. Statistics indicate that approximately 92 percent of the alcoholics will be correctly identified.

The Michigan Alcoholism Screening Test (MAST) was developed to separate alcoholics from non-alcoholics. This test was to be used as a device for screening rather than as a fully diagnostic instrument. This tool has been found (Selzer, et al, 1975) to detect alcoholism about 98 percent of the time and yield a false response only 5 percent of the time. According to Selzer, the reliability of its internal consistency was determined by coefficient alpha, any yielded

coefficients of .83-Group G and .87-Group A. and .95 for the entire sample. The validity of the MAST was determined by a product-moment correlation and coefficient and Goodman's gamma. These methods yielded a validity coefficient of r=.79 and gamma .95, indicating that alcoholics score higher.

Scores of 0-4 points are considered non-alcoholic, 5-6 points are suggestive of alcoholism (except for positive responses to questions 8, 19, and 20 which are considered diagnostic), and 7 or more points as indicative of alcoholism.

The Shostrom Personal Orientation Inventory (POI) was developed and presented in a report by Shostrom (1964). He found ". . . that the inventory significantly discriminates between clinically judged actualized and non-actualized groups on 11 of the 12 scales. This conclusion was based on reliability coefficient of .91 and .93 established by test-retest methods."

Klovetter and Mogor (1967) reported that "Stability coefficients are generally high, ranging from .71 to .85" and that "These tentative results suggest that scores on the POI are highly stable and sufficiently valid measure of health-growth dimensions of personal functioning."

Shostrom and Knopp (1966) concluded: "Analysis of the POI scores showed all 12 scales differentiated between the criterion groups at the .01 levels of confidence or higher."

Investigating the possibilities of faking on the POI (Braun and Asta 1969; Braun and La Faro 1969) demonstrates: "Persons rather consistently score lower on self-actualization when trying to make a good impression than they do when trying to be honest, and on twenty-three of these 48 T-tests were significant differences showing lower self-actualization scores when faking."

Knapp (1976) states, "The typical alcoholic profile is low, generally about one standard deviation below the 'normal' adult mean." In addition, low scores were noted on the Time Competence and Synergy scales. The lower Time Competence scale score had previously been reported by Shostrom. It would appear that alcoholics are apt to live in past or future events.

Three studies, Weir (1965), Weir and Gade (1969), and Zaccaria and Weir (1967), reported, ". . . that seventy alcoholics and their spouses who were participating in an alcoholic program. They found all mean POI scores for the sample to be significantly lower than the original validating, clinically nominated, self-actualizing sample."

Analysis of the Data

A mixed model one-factor experiment with repeated measurements was the experimental design utilized in this study.

In explaining the repeated measures concept of experimental design, Winer (1962) states:

> . . . the primary purpose of repeated measure on the same elements is the control that this kind of design

> provides over individual differences between experimental units. In the area of the behavioral sciences, differences between such units often are quite large relative to differences in treatment effects which the experimenter is trying to evaluate. Another advantage of a repeated-measures design is in terms of economy of S_s. Using different S_s under each of the treatment combinations in a factorial experiment has the marked advantage of providing statistically indepentent observations is very likely to be the best way of increasing the precision of estimators. By having each S serve as his own control, the experimenter attempts to work with a smaller sample size.

He continues:

> Since all the observations within the groups have been made under the same treatment combination, effects associated with the treatment per se have been held constant. Hence the treatment effects per se are not contributing to the within group variance. Differences between units of the experimental material existing prior to the experimental treatment, variance introduced by inaccuracies or uncontrolled changes in experimental techniques, possess unique interactions between the material and the treatments--all these sources contribute to within group variance.

This is to say that each S serves as his own control. By doing so, much of the variance due to variables other than treatment variance becomes accountable (Appendix 8).

The present work, like many experiments in the social sciences involves the repeated testing of the same sample of subjects under different conditions, i.e., at different points in time. Winer (1962) has discussed in detail the treatment of this "repeated measures" type of experiment. More precisely, the experimental design of this study is a one-factor experiment with repeated measurements, and the data were analyzed by a two-way analysis of variance with time as the second factor. Since the subjects were assigned to the groups in a random manner, while the

pre- and post-treatment observations are fixed time parts, the appropriate analysis model is the mixed model and, therefore, the computational model used in the analysis of this data. Referring to Table 5, if the Time of measurement is considered the column effect and Group number the row effect, then we have $C=C_p$ and $(C_p-C)/C=0$. Also, $R_p \gg R$ and hence $(R_p-R)/R_p=1$. The appropriate test for column effect is $F_r=S_r^2/S_w^2$. The test of significance for interaction between these two factors is given by $F_i=S_i^2/S_w^2$.

TABLE 5

EXPECTATION OF MEAN SQUARES FOR GENERAL FINITE MODEL: TWO-WAY ANALYSIS OF VARIANCE WITH n ENTRIES IN EACH GROUP: N > 1

Mean Square	Expectation of Mean Square
Row, s_r^2	$o_e^2 + \frac{(O-C)}{C_p} no_{ab}^2 + nCo_a^2$
Column, s_c^2	$o_e^2 + no_{ab}^2 + nRo_b^2$
Between Groups, s_i^2	$o_e^2 + no_{ab}^2$
Within Groups, s_w^2	o_e^2

One of the problems encountered in the study was the number of S drop-outs. Some Ss did not follow through on their initial commitment to the research.

Results

The homogeneous nature of the groups was determined by matching the S_s for socio-economic level, age, sex, race, educational and work experiences, and marital status (see table 6). There were no changes for the S_s in the pre- and post-test conditions of: socio-economic level, age, sex, race, educational and work experiences and marital status.

All subjects were assigned to either Group I or Group II. Each subject agreed to attend twelve (12) weekly treatment sessions and accept a non-drinking behavior contract. Fifteen (15) subjects were randomly assigned to Group I or II, and nine (9) subjects completed twelve (12) weeks participation in the study.

All S_s by self-report identified themselves as alcohol-abusers and presented an extended behavioral history of alcohol-abuse. Eleven (11) subjects reported a multi-drug or substance abuse history, and four (4) subjects reported no such history. S_s test scores on the Cage Questions and Michigan Alcoholism Screening Test (MAST) confirmed the identification of themselves as abusers of alcohol. The mean test scores of the two tests, dependent variables one and two, showed no significant differences in pre- and post-test conditions (see tables 7 and 8).

The purpose of the study was to investigate the non-drinking contract effort when used as a therapeutic tool in the treatment of alcohol-abuse. Therefore, the following conditions were instrumented: (1) the S_s would attend weekly

treatment sessions, (2) Ss would accept weekly non-drinking behavior contracts, and (3) abstain from alcohol ingestion. These conditions were adhered to (see table 9). In Group I and Group II, all Ss attended twelve (12) treatment sessions 100 percent of the time, and all Ss accepted and signed weekly non-drinking behavior contracts. In Group I 97.0 percent of Ss kept their non-drinking contract, and in group II 86.4 percent of the Ss kept their non-drinking contract.

To assess the possible influence of previous exposure to Alcoholics Anonymous on the subjects in this study, all Ss were asked about their participation in this organization. Twelve (12) subjects had no involvement and had never attended an A.A. meeting. Three (3) subjects were currently attending A.A. meetings on a weekly basis, however, all three were currently and actively abusing alcohol. The latter three (3) subjects did participate in the study and all three (3) reported being abstinent throughout and at the end of the twelve (12) week period.

The statistical analysis of the twelve (12) dependent variables, as measured by the Shostrom Personal Orientation Inventory (POI), three (3) through fourteen (14), for Group I and Group II shows no significant differences on pre- and post-test score measurements (see tables 10 through 21).

TABLE 6

DEMOGRAPHIC INFORMATION

Age			
Group	Pre	Post	No. Persons in Group
I	46.0	46.3	3
II	39.5	39.6	6
III	31.5	....	6

Education	
Group	Years
I	12.0
II	13.5
III	13.8

TABLE 7

VARIABLE 1--CAGE QUESTIONS

Group	Pre	Post	$\bar{X}_r$
I	3.66	3.66	3.66
II	3.83	3.83	3.83
$\bar{X}_c$	3.77	3.77	....

VARIABLE 1--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	0.111	2	0.056	0.259
Pre/post	0.000	1	0.000	0.000
Group no.	0.111	1	0.111	0.519
2-way interaction	0.000	1	0.000	0.000
Pre/post group no. (Between groups)	0.000	1	0.000	0.000
Variation	0.111	3	0.037	0.173
Residual (Within group)	3.000	14	0.214	.....
Total	3.111	17	0.183	.....

TABLE 8

VARIABLE 2--MICHIGAN ALCOHOLISM SCREENING TEST-MAST

Group	Pre	Post	$\bar{X}_r$
I	29.00	31.33	30.16
II	31.66	32.50	32.08
$\bar{X}_c$	30.77	32.11	.....

VARIABLE 1--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	22.694	2	11.347	0.057
Pre/post	8.000	1	8.000	3.555
Group no.	14.694	1	14.694	0.074
2-way interaction	2.250	1	2.250	0.011
Pre/post group no. (Between groups)	2.250	1	2.250	0.011
Variation	24.945	3	8.315	0.042
Residual (Within group)	2795.499	14	199.678	.....
Total	2820.443	17	165.908	.....

TABLE 9

SESSIONS ATTENDED

Group	No.	Percent
I	12	100.0
II	12	100.0
III	45	37.5

NO. OF CONTRACTS KEPT

Group	No.	Percent
I	10.66	97.0
II	9.5	86.4
III	3.0	27.3

TABLE 10

VARIABLE 3--TIME COMPETENCE

Group	Pre	Post	$\bar{X}_r$
I	15.667	14.333	15.000
II	15.667	17.500	16.583
$\bar{X}_c$	15.667	16.444	.....

VARIABLE 3--2 WAY ANALYSIS OF VARIANCE REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	12.750	2	6.375	0.326
Pre/post	2.722	1	0.271	0.139
Group no.	10.028	1	10.028	0.512
2-way interaction	10.028	1	10.028	0.512
Pre/post group no. (Between groups)	10.028	1	10.028	0.512
Variation	22.778	3	7.593	0.388
Residual (Within group)	274.166	14	19.583	.....
Total	296.944	17	17.467	.....

TABLE 11

VARIABLE 4--INNER-OTHER DIRECTED

Group	Pre	Post	$\bar{X}_r$
I	87.333	83.667	85.500
II	78.833	83.000	80.917
$\bar{X}_c$	81.667	83.222	.....

VARIABLE 4--2 WAY ANALYSIS OF VARIANCE REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	94.917	2	47.458	0.232
Pre/post	10.889	1	10.889	0.177
Group no.	84.028	1	84.028	0.411
2-way interaction	61.361	1	61.361	0.300
Pre/post group no. (Between groups)	61.361	1	61.361	0.300
Variation	156.278	3	52.093	0.255
Residual (Within group)	2864.165	14	204.583	.....
Total	3020.443	17	177.673	.....

TABLE 12

VARIABLE 5--SELF-ACTUALIZING VALUES

Group	Pre	Post	$\bar{X}_r$
I	19.333	19.000	19.167
II	19.000	20.333	19.667
$\bar{X}_c$	19.111	19.889	.....

VARIABLE 5--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	3.722	3	1.861	0.290
Pre/post	2.722	1	2.722	0.980
Group no.	1.000	1	1.000	0.156
2-way interaction	2.778	1	2.778	0.432
Pre/post group no. (Between groups)	2.778	1	2.778	0.432
Variation	6.500	3	2.167	0.337
Residual (Within group)	90.000	14	6.429	.....
Total	96.500	17	5.676	.....

TABLE 13

VARIABLE 6--EXISTENTIALITY

Group	Pre	Post	$\bar{X}_r$
I	20.667	22.000	21.333
II	18.833	19.333	19.083
$\bar{X}_c$	19.444	20.222	.....

VARIABLE 6--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	22.972	2	11.486	0.284
Pre/post	2.722	1	2.722	3.920
Group no.	20.250	1	20.250	0.500
2-way interaction	0.694	1	0.694	0.017
Pre/post group no. (Between groups)	0.694	1	0.694	0.017
Variation	23.667	3	7.889	0.195
Residual (Within group)	566.833	14	40.488	.....
Total	590.499	17	34.735	.....

TABLE 14

VARIABLE 7--FEELING REACTIVITY

Group	Pre	Post	$\bar{X}_r$
I	16.667	15.667	16.167
II	15.000	15.000	15.000
$\bar{X}_c$,	15.556	15.222	.....

VARIABLE 7--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	5.944	2	2.972	0.657
Pre/post	0.500	1	0.500	0.500
Group no.	5.444	1	5.444	1.204
2-way interaction	1.000	1	1.000	0.221
Pre/post group no. (Between groups)	1.000	1	1.000	0.221
Variation	6.944	3	2.315	0.512
Residual (Within group)	63.333	14	4.524	.....
Total	70.278	17	4.134	.....

TABLE 15

VARIABLE 8--SPONTANEITY

Group	Pre	Post	$\bar{X}_r$
I	14.000	13.667	13.833
II	12.333	12.167	12.250
$\bar{X}_c$	12.889	12.667	.....

VARIABLE 8--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	10.250	2	5.125	0.910
Pre/post	0.222	1	0.222	7.928
Group no.	10.028	1	10.028	1.781
2-way interaction	0.028	1	0.028	0.005
Pre/post group no. (Between groups)	0.028	1	0.028	0.005
Variation	10.278	3	3.426	0.608
Residual (Within group)	78.833	14	5.631	.....
Total	89.111	17	5.242	.....

TABLE 16

VARIABLE 9--SELF-REGARD

Group	Pre	Post	$\bar{X}_r$
I	11.667	11.667	11.667
II	11.167	11.500	11.333
$\bar{X}_c$	11.333	11.556	.....

VARIABLE 9--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	0.667	2	0.333	0.045
Pre/post	0.222	1	0.222	2.000
Group no.	0.444	1	0.444	0.060
2-way interaction	0.111	1	0.111	0.015
Pre/post group no. (Between groups)	0.111	1	0.111	0.015
Variation	0.778	3	0.259	0.035
Residual (Within group)	103.667	14	7.405	.....
Total	104.444	17	6.144	.....

TABLE 17

VARIABLE 10--SELF-ACCEPTANCE

Group	Pre	Post	X_r
I	18.000	15.667	16.833
II	14.667	16.833	15.750
$\bar{X}_C$	15.778	16.444	.....

VARIABLE 10--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	6.694	2	3.347	0.180
Pre/post	2.000	1	2.000	0.099
Group no.	4.694	1	4.694	0.252
2-Way interaction	20.250	1	20.250	1.087
Pre/post group no. (Between groups)	20.250	1	20.250	1.087
Variation	26.945	3	8.982	0.482
Residual (Within group)	260.833	14	18.631	.....
Total	287.777	17	16.928	.....

TABLE 18

VARIABLE 11--NATURE OF MAN

Group	Pre	Post	$\bar{X}_r$
I	11.667	9.667	10.667
II	11.167	11.667	11.417
$\bar{X}_c$	11.333	11.000	.....

VARIABLE 11--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	2.750	2	1.375	0.443
Pre/post	0.500	1	0.500	0.080
Group no.	2.250	1	2.250	0.724
2-way interaction	6.250	1	6.250	2.011
Pre/post group no. (Between groups)	6.250	1	6.250	2.011
Variation	9.000	3	3.000	0.966
Residual (Within group)	43.500	14	3.107	.....
Total	52.500	17	3.088	.....

TABLE 19

VARIABLE 12--SYNERGY

Group	Pre	Post	$\bar{X}_r$
I	6.333	5.333	5.833
II	5.833	6.833	6.333
$\bar{X}_c$	6.000	6.333	.....

VARIABLE 12--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	1.500	2	0.750	0.808
Pre/post	0.500	1	0.500	0.125
Group no.	1.000	1	1.000	1.077
2-way interaction	4.000	1	4.000	4.308
Pre/post group no. (Between groups)	4.000	1	4.000	4.308
Variation	5.500	3	1.833	1.974
Residual (Within group)	13.000	14	0.929	.....
Total	18.500	17	1.088	.....

TABLE 20

VARIABLE 13--ACCEPTANCE OF AGGRESSION

Group	Pre	Post	$\bar{X}_r$
I	16.000	15.333	15.667
II	16.833	16.333	16.583
$\bar{X}_c$	16.556	16.000	.....

VARIABLE 13--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	4.750	2	2.375	0.295
Pre/post	1.389	1	1.389	49.607
Group no.	3.361	1	3.361	0.417
2-way interaction	0.028	1	0.028	0.003
Pre/post group no. (Between groups)	0.028	1	0.028	0.003
Variation	4.778	3	1.595	0.198
Residual (Within group)	112.833	14	8.060	.....
Total	117.611	17	6.918	.....

TABLE 21

VARIABLE 14--CAPACITY FOR INTIMATE CONTACT

Group	Pre	Post	$\bar{X}_r$
I	19.667	19.333	19.500
II	18.000	17.833	17.917
$\bar{X}_c$	18.556	18.333	.....

VARIABLE 14--2 WAY ANALYSIS OF VARIANCE-REPEATED MEASUREMENTS

Source of Variation	Sum of Squares	D.F.	Mean Squares	F
Main effect	10.250	2	5.125	0.296
Pre/post	0.222	1	0.222	7.928
Group no.	10.028	1	10.028	0.580
2-way interaction	0.028	1	0.028	0.002
Pre/post group no. (Between groups)	0.028	1	0.028	0.002
Variation	10.278	3	3.426	0.198
Residual (Within group)	242.157	14	17.298	.....
Total	252.444	17	14.850	.....

Mean scores, pre- and post-test for Groups I and II, of the twelve dependent variables: (1) Time Competence, (2) Inner-Other directed, (3) Self-Actualizing values, (4) Existentiality, (5) Feeling Reactivity, (6) Spontaneity, (7) Self-Regard, (8) Self-Acceptance, (9) Nature of Man, (10) Synergy, (11) Acceptance of Aggression, and (12) Capacity for Intimate Contact are graphically portrayed (see figures 1,2).

The mean scores, pre- and post-test measurements, for Groups I and II, for the twelve (12) dependent variables show no significant statistical differences as illustrated (see figure 3).

One of the problems encountered in this study was the drop-out of subjects. Those who dropped out were assigned to Group III, and data available were submitted to statistical analysis.

These $\underline{S_s}$ were part of the original fifteen (15) subjects that were randomly assigned to either Group I or Group II. They were all alcohol-abusers as identified by self-report, the Cage Questions and the Michigan Alcoholism Screening Test (MAST). All agreed to participate in the study and did in fact begin participation.

Mean scores of the twelve dependent variables on Pre-test measurements for Group I, II, and III were computed and analyzed. Although Group III scores tended to be lower, no statistically significant differences were found. Group III mean scores for the POI are shown graphically (see figure 4).

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

NAME GROUP I DATE TESTED PRE & POST

AGE _____ SEX _____

OCCUPATION _____

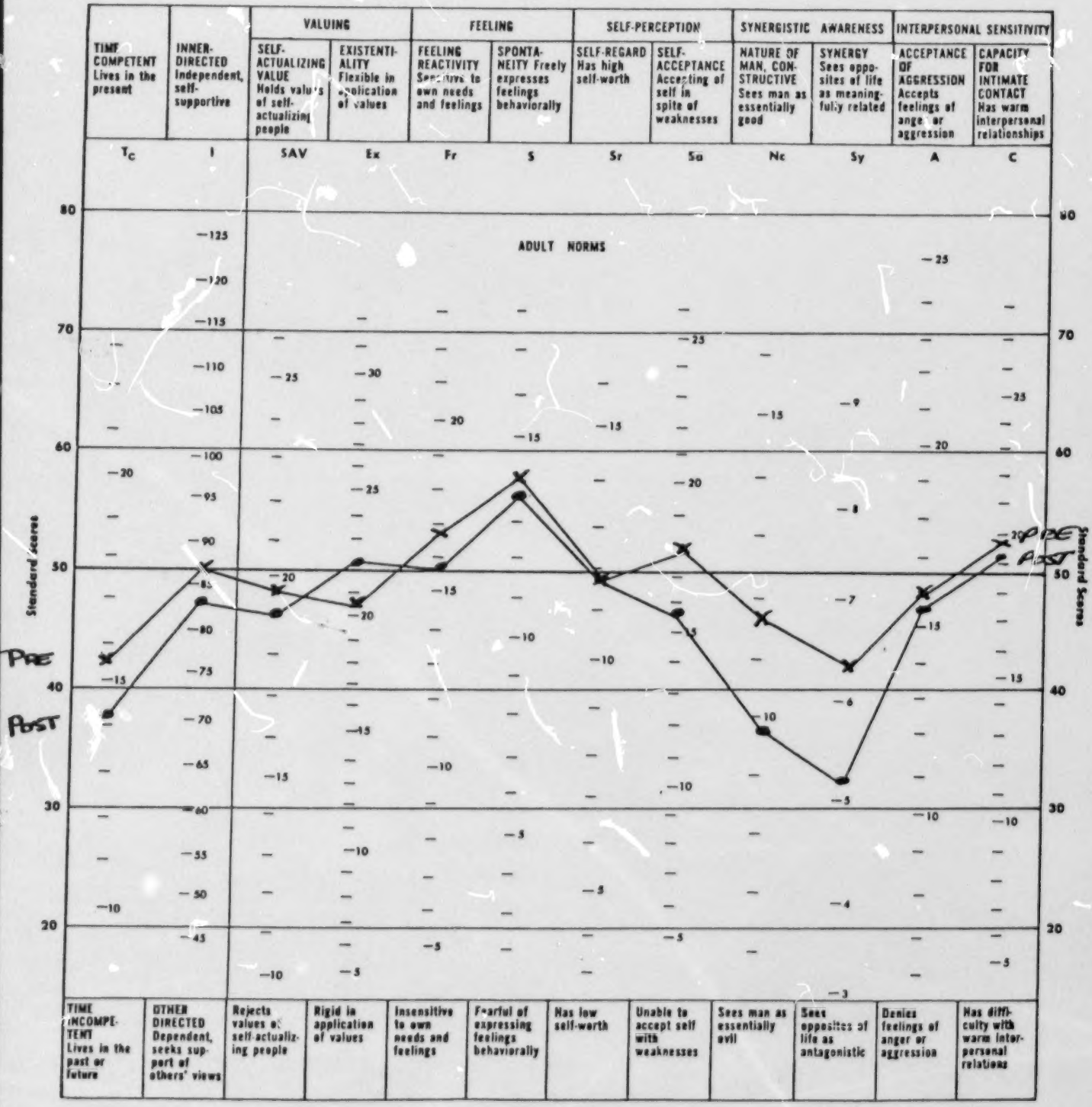
FIGURE I

I $T_I - T_C$ (Time) Ratio:
Self-Actualizing Average: $T_I : T_C = 1:8$
Your Ratio: $T_I : T_C = 1:$ __

1									
1	2	3	4	5	6	7	8	9	10

II O - I (Support) Ratio:
Self-Actualizing Average: O:I = 1:3
Your Ratio: O:I = 1:__

1									
1	2	3	4	5	6	7	8	9	10



Raw Scores

COPYRIGHT © 1963, 1965 by EDUCATIONAL & INDUSTRIAL TESTING SERVICE, SAN DIEGO, CALIFORNIA 92107
REPRODUCTION OF THIS FORM BY ANY MEANS STRICTLY PROHIBITED

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

NAME GROUP II DATE TESTED PRE & POST

AGE _____ SEX _____

OCCUPATION _____

FIGURE 11

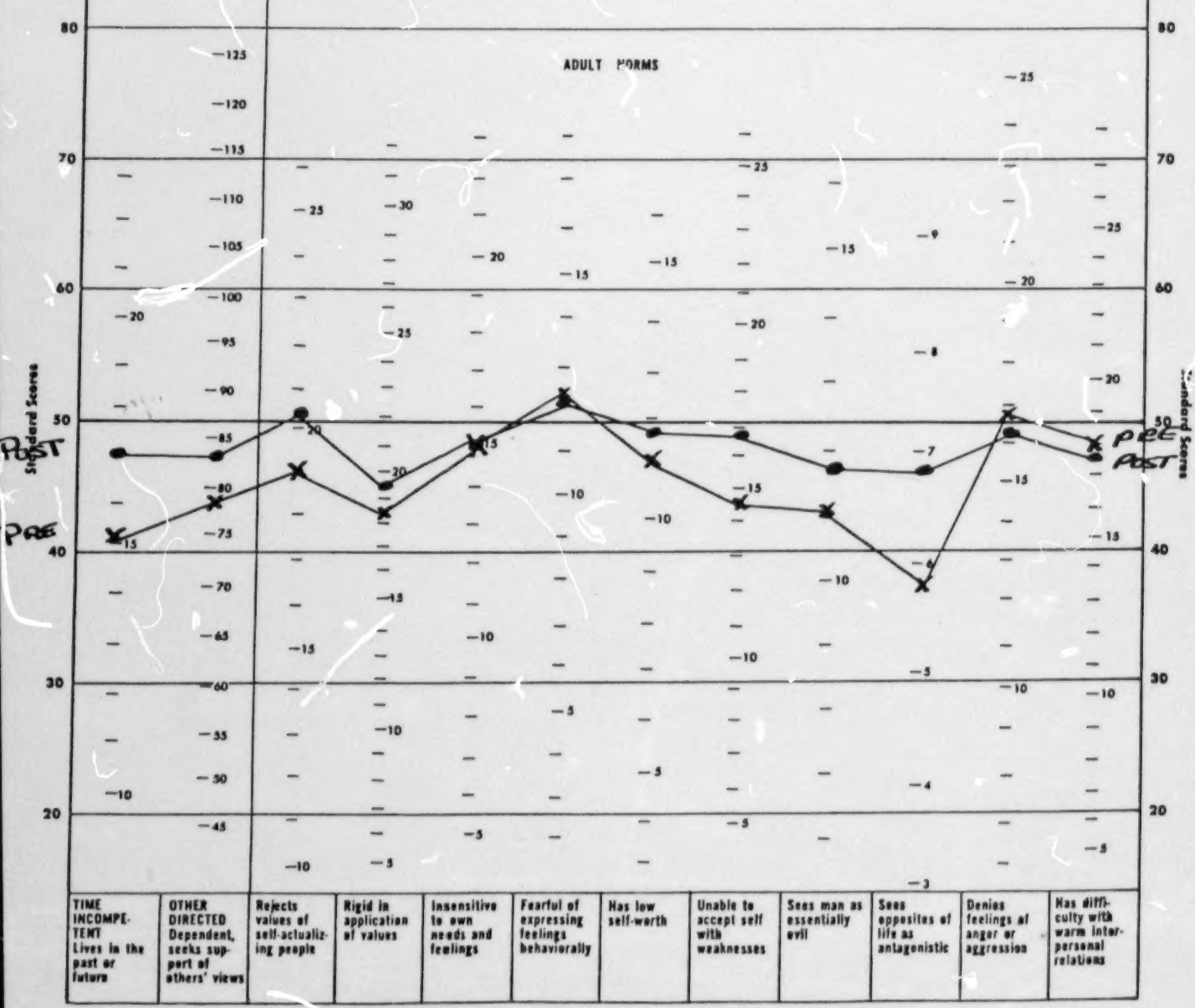
I $T_I - T_C$ (Time) Ratio:
Self-Actualizing Average: $T_I : T_C = 1:8$
Your Ratio: $T_I : T_C = 1:$ __

1									
1	2	3	4	5	6	7	8	9	10

II O - I (Support) Ratio:
Self-Actualizing Average: O:I = 1:3
Your Ratio: O:I = 1:__

1									
1	2	3	4	5	6	7	8	9	10

TIME COMPETENT Lives in the present	INNER-DIRECTED Independent, self-supportive	VALUING: SELF-ACTUALIZING VALUE Holds values of self-actualizing people	VALUING: EXISTENTIALITY Flexible in application of values	FEELING: FEELING REACTIVITY Sensitive to own needs and feelings	FEELING: SPONTANEITY Freely expresses feelings behaviorally	SELF-PERCEPTION: SELF-REGARD Has high self-worth	SELF-PERCEPTION: SELF-ACCEPTANCE Accepting of self in spite of weaknesses	SYNERGISTIC AWARENESS: NATURE OF MAN, CONSTRUCTIVE Sees man as essentially good	SYNERGISTIC AWARENESS: SYNERGY Sees opposites of life as meaningfully related	INTERPERSONAL SENSITIVITY: ACCEPTANCE OF AGGRESSION Accepts feelings of anger or aggression	INTERPERSONAL SENSITIVITY: CAPACITY FOR INTIMATE CONTACT Has warm interpersonal relationships
T_C	I	SAV	Ex	Fr	S	Sr	Sa	Nc	Sy	A	C



TIME INCOMPETENT Lives in the past or future	OTHER DIRECTED Dependent, seeks support of others' views	Rejects values of self-actualizing people	Rigid in application of values	Insensitive to own needs and feelings	Fearful of expressing feelings behaviorally	Has low self-worth	Unable to accept self with weaknesses	Sees man as essentially evil	Sees opposites of life as antagonistic	Denies feelings of anger or aggression	Has difficulty with warm interpersonal relations

Raw Scores

COPYRIGHT © 1962, 1965 by EDUCATIONAL & INDUSTRIAL TESTING SERVICE, SAN DIEGO, CALIFORNIA 92107
REPRODUCTION OF THIS FORM BY ANY MEANS STRICTLY PROHIBITED

EITS POI 040

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

NAME GROUPS I & II DATE TESTED PRE & POST

AGE _____ SEX _____

OCCUPATION _____

FIGURE III

I $T_I - T_C$ (Time) Ratio:
Self-Actualizing Average: $T_I : T_C = 1:8$
Your Ratio: $T_I : T_C = 1:$ __

1									
1	2	3	4	5	6	7	8	9	10

II O - I (Support) Ratio:
Self-Actualizing Average: O:I = 1:3
Your Ratio: O:I = 1: __

1									
1	2	3	4	5	6	7	8	9	10

TIME COMPETENT Lives in the present	INNER-DIRECTED Independent, self-supportive	VALUING: SELF-ACTUALIZING VALUE Holds values of self-actualizing people	VALUING: EXISTENTIALITY Flexible in application of values	FEELING: FEELING REACTIVITY Sensitive to own needs and feelings	FEELING: SPONTANEITY Freely expresses feelings behaviorally	SELF-PERCEPTION: SELF-REGARD Has high self-worth	SELF-PERCEPTION: SELF-ACCEPTANCE Accepting of self in spite of weaknesses	SYNERGISTIC AWARENESS: NATURE OF MAN, CONSTRUCTIVE Sees man as essentially good	SYNERGISTIC AWARENESS: SYNERGY Sees opposites of life as meaningfully related	INTERPERSONAL SENSITIVITY: ACCEPTANCE OF AGGRESSION Accepts feelings of anger or aggression	INTERPERSONAL SENSITIVITY: CAPACITY FOR INTIMATE CONTACT Has warm interpersonal relationships
T_C	I	SAV	Ex	Fr	S	Sr	Sa	Nc	Sy	A	C

Standard Scores

ADULT NORMS

POST

PRE

TIME INCOMPETENT Lives in the past or future	OTHER DIRECTED Dependent, seeks support of others' views	Rejects values of self-actualizing people	Rigid in application of values	Insensitive to own needs and feelings	Fearful of expressing feelings behaviorally	Has low self-worth	Unable to accept self with weaknesses	Sees man as essentially evil	Sees opposites of life as antagonistic	Denies feelings of anger or aggression	Has difficulty with warm interpersonal relations

Raw Scores

COPYRIGHT © 1963, 1965 by EDUCATIONAL & INDUSTRIAL TESTING SERVICE, SAN DIEGO, CALIFORNIA 92107
REPRODUCTION OF THIS FORM BY ANY MEANS STRICTLY PROHIBITED

EDITS POI 040

PROFILE SHEET FOR THE PERSONAL ORIENTATION INVENTORY

NAME GROUP III DATE TESTED PRE

AGE _____ SEX _____

OCCUPATION _____

FIGURE IV

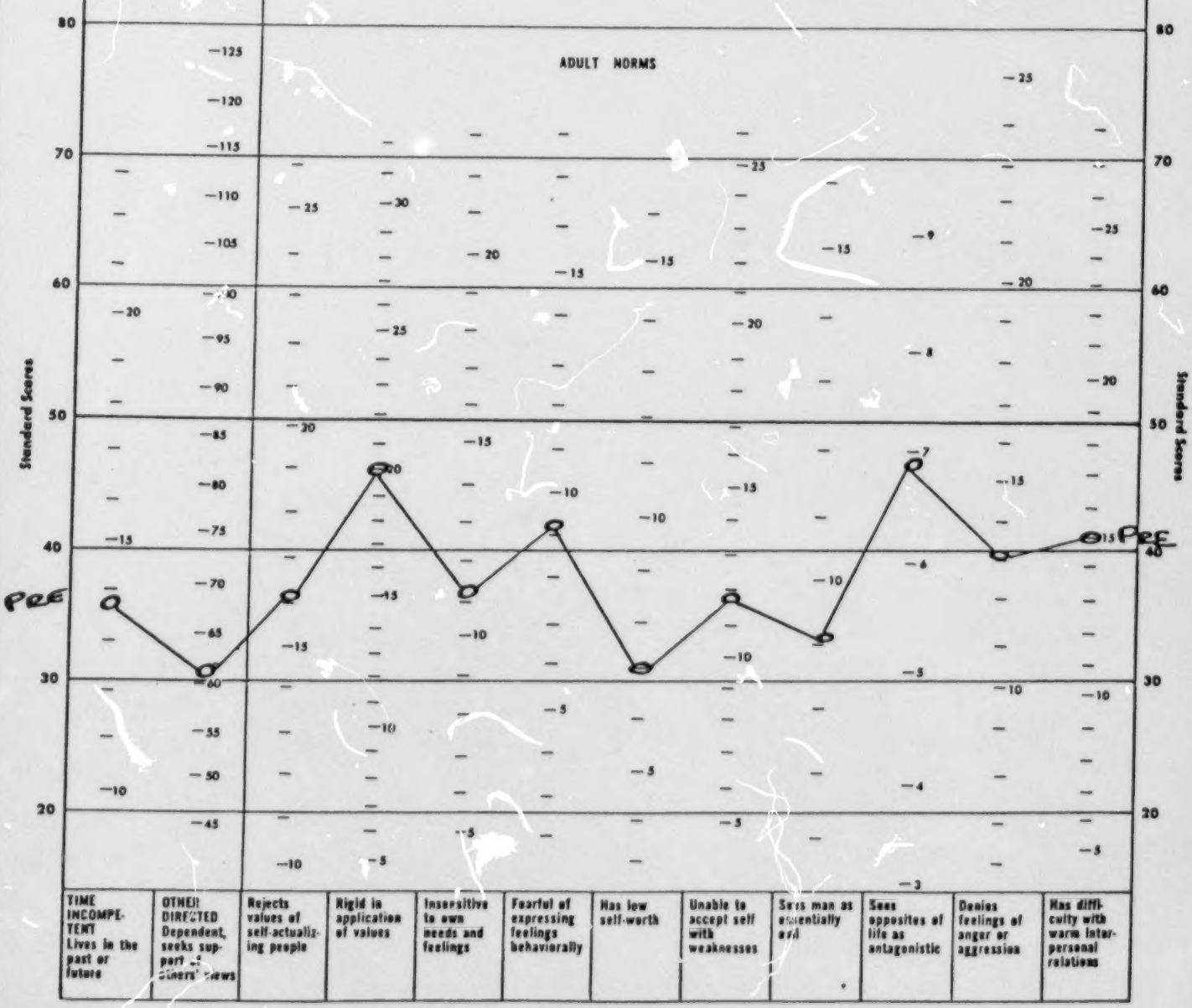
I $T_I - T_C$ (Time) Ratio:
Self-Actualizing Average: $T_I : T_C = 1:8$
Your Ratio: $T_I : T_C = 1:$ __

1									
1	2	3	4	5	6	7	8	9	10

II O - I (Support) Ratio:
Self-Actualizing Average: O:I = 1:3
Your Ratio: O:I = 1: __

1									
1	2	3	4	5	6	7	8	9	10

		VALUING		FEELING		SELF-PERCEPTION		SYNERGISTIC AWARENESS		INTERPERSONAL SENSITIVITY	
TIME COMPETENT Lives in the present	INNER-DIRECTED Independent, self-supportive	SELF-ACTUALIZING VALUE Holds values of self-actualizing people	EXISTENTIALITY Flexible in application of values	FEELING REACTIVITY Sensitive to own needs and feelings	SPONTANEITY Freely expresses feelings behaviorally	SELF-REGARD Has high self-worth	SELF-ACCEPTANCE Accepting of self in spite of weaknesses	NATURE OF MAN, CONSTRUCTIVE Sees man as essentially good	SYNERGY Sees opposites of life as meaningfully related	ACCEPTANCE OF AGGRESSION Accepts feelings of anger or aggression	CAPACITY FOR INTIMATE CONTACT Has warm interpersonal relationships
T_C	I	SAV	Ex	Fr	S	Sr	Sa	Nc	Sy	A	C



TIME INCOMPETENT Lives in the past or future	OTHER DIRECTED Dependent, seeks support of others' views	Rejects values of self-actualizing people	Rigid in application of values	Insensitive to own needs and feelings	Fearful of expressing feelings behaviorally	Has low self-worth	Unable to accept self with weaknesses	Sees man as essentially evil	Sees opposites of life as antagonistic	Denies feelings of anger or aggression	Has difficulty with warm interpersonal relations

Low Scores

COPYRIGHT © 1963, 1965 by EDUCATIONAL & INDUSTRIAL TESTING SERVICE, SAN DIEGO, CALIFORNIA 92107
REPRODUCTION OF THIS FORM BY ANY MEANS STRICTLY PROHIBITED

EdITS POI 040

Discussion

The results of the data confirms the effectiveness of the contract as a tool that has positive value at the beginning of the treatment process. Further, this study confirms the theoretical position of Steiner (1967) in which he states the possibility of effecting a symptom cure in three (3) months. The $\underline{S_s}$ in this study, by accepting a non-drinking behavioral contract for twelve (12) treatment sessions, were able to move from a position of alcohol-abuse to a position of abstinence from alcohol. A symptom cure was effected for these subjects. We see advantages of a symptom cure--abstinence from alcohol: (1) improvement of one's physical condition, (2) the $\underline{S_s}$ avoidance of alcohol as a substitute and escape from problems, (3) the decision not to use alcohol as a defense mechanism, (4) eliminating a drug that would interfere with relearning, memory, and the treatment process, (5) the preparation for exploration of deeper personal issues and life theme patterns, and, finally, (6) a trusting rapport is established between the therapist and client.

The individuals who participated were motivated to improve and change. They agreed to participate in the study with a personal attitude that they needed to change their alcohol-ingestion behavioral patterns. A tension for self-improvement existed within each person prior to study. As a result of accepting a contract a second tension was created, that is, a goal was established between subject and therapist

that suggested there was a way to move from drinking behavior to non-drinking behavior. Individuals arrived with an attitude and motivation to improvement, accepted the non-drinking contract, had an expectation and an agreement that their behavior would change, and it did. There was a positive matching of attitude and behavior.

Several external influences that could have effected the results of this study were: Alcoholics Anonymous involvement; therapist skill level; and the nature of control conditions.

Twelve (12) subjects have never been involved with A.A. They had not attended meetings prior to this study and and did not attend any meetings while participating. They were not encouraged to attend or not to attend. Of the subjects, six (6) successfully discontinued their negative drinking behavior. Three (3) subjects had a history of attending A.A. meetings, although they had not stopped drinking. Following this study, these three had also completely stopped their drinking behavior. It appears that A.A. influences were not significant influences on this study.

Therapist skill level and knowledge in the use of the contract were considered as possible influences that might effect the outcome of this study. In order to avoid these influences two beginning level therapists, both undergraduate level students, one male and one female, were selected as therapists for this project. As to knowledge of

the contract, neither was aware of the nature or dimensions of the contract as a therapeutic tool. Neither had read the works of Steiner. Prior to the beginning of the treatment sessions, both therapists spent two (2) hours in a "contract" training session.

The subject-selection procedure was carefully evaluated for this study, especially in terms of treatment and control conditions. First, in order to demonstrate that change had occurred in behavior, it was important to show that the conditions compared were different. Here we see a change from drinking behavior to non-drinking behavior, a difference. One problem here is the reliability of self-reported changed behavior. It has, however, been a standard clinically accepted practice to accept a $\underline{S}_S$ report of improvement and change. Second, the $\underline{S}_S$ were carefully matched, time and group assignment were used as controls, and finally fourteen (14) dependent variables were computed on a pre-treatment baseline measurement and a post-treatment measurement. Third, we needed to review the use of subjects as their own control. This is a straight-forward sequential model: assessment before treatment, treatment, assessment after treatment. For factors one and three, all $\underline{S}_S$ completed all pre- and post-test data measurements, and the treatment program--especially, use of the contract was precisely defined and executed.

Another set of assumptions for this study was that $\underline{S}_S$ would demonstrate changes in their daily life situations

and would also demonstrate changes on the Cage Questions, MAST, and Personal Orientation Inventory (POI). Both assumptions were not supported. The pre- and post-treatment conditions were not significantly different. This result also supports the works of Steiner (1967) who states that life theme (script) patterns and personality issues would not begin to occur until an individual has been involved in the treatment process for a minimum of one (1) year. Any program designed for the treatment of alcohol-abuse must take into consideration the fact that alcohol-abuse does not exist by itself but is part of a personality malformation. Successful rehabilitation involves removal of the symptom and changes in the total personality.

Two problems with this study were: the drop-out rate of Ss and the sample size. Six (6) Ss dropped out of the treatment program. We can speculate that Ss left because: (1) of their fears of changing behavior patterns, (2) of not really being committed to improvement, and (3) a researcher might expect by chance alone a certain drop-out rate as being characteristic of the population being studied. Although the study sample was small, the consistency and significance of the findings indicate that similar results could be obtained if the study were conducted on a larger scale. Therefore, the contract is a good tool to use with alcoholics at the beginning of therapy.

Summary

The purpose of this study was to evaluate the effectiveness of the contract as a positive tool in the treatment process. Further, by demonstrating the value of the contract in the beginning of the treatment process and by demonstrating that an individual who is currently abusing alcohol would abstain from alcohol, thereby producing a symptom cure. Another aspect of this study was on evaluation of pre- and post-changes in daily life patterns and changes in their personal orientation toward themselves and others.

Fifteen (15) $\underline{S}_{\underline{s}}$ were selected and assigned to one of two treatment groups. All $\underline{S}_{\underline{s}}$ completed pre- and post-treatment measures: Personal History Questionnaire, Cage Questions, Michigan Alcoholism Screening Test (MAST), and a Personal Orientation Inventory (POI). Each $\underline{S}$ participated in (12) treatment sessions. On a weekly basis each $\underline{S}$ accepted and signed a contract for non-drinking behavior.

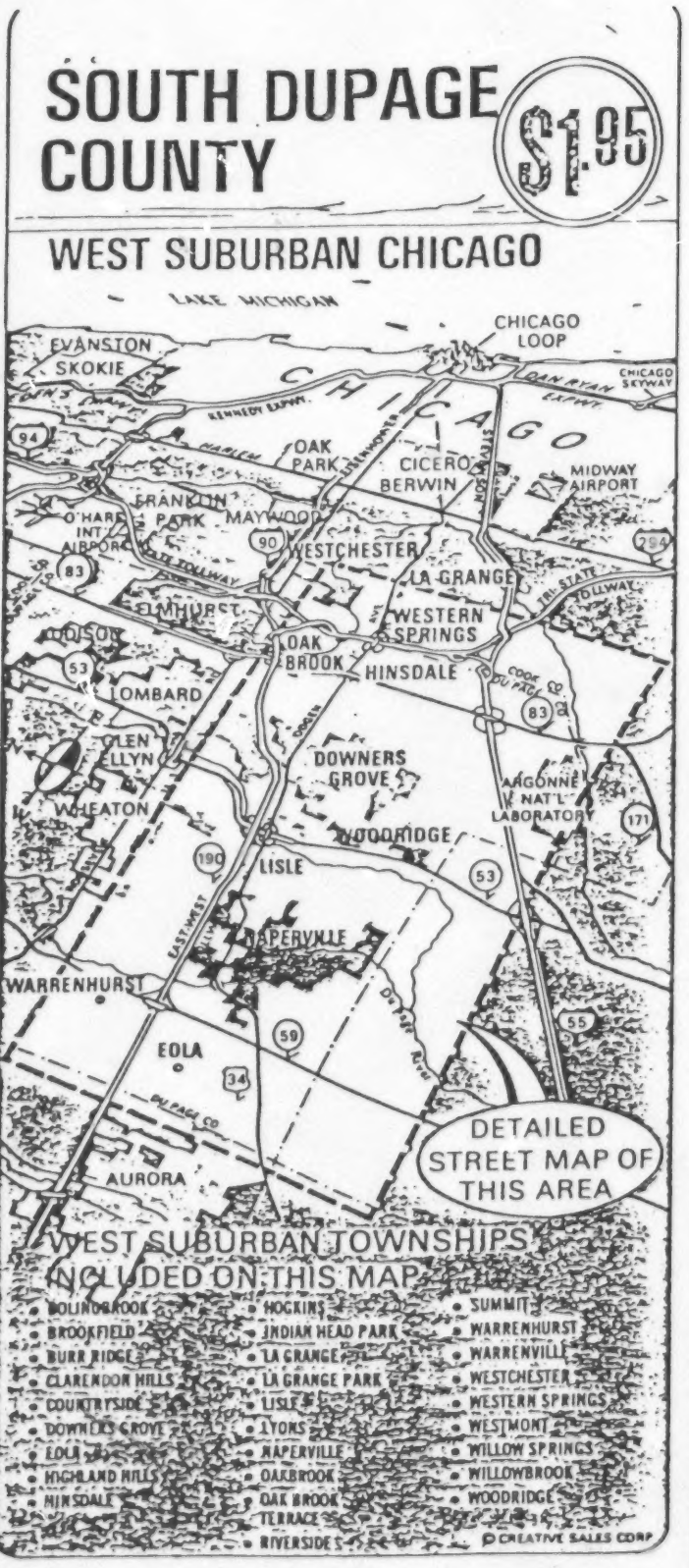
Analysis of the data revealed that the subjects in Group I and II attended 100 percent of the twelve (12) treatment sessions. In Group I 97.0 percent of the subjects kept their weekly non-drinking behavioral contract and in Group II 86.4 percent of the subjects kept their weekly non-drinking behavioral contract. Each subject served as one's own control. Data were computed by analysis of variance on a repeated test measure design. There were no statistically significant differences for the mean scores on all pre- and post-treatment measurements.

Final results disclosed that a change in behavior did occur. Ss who prior to participation in this study were abusing alcohol did stop drinking. A symptom cure did occur. The findings supported the use of the contract in the beginning of the treatment process. There were no changes in daily life patterns or personal orientation.

Finally, the study, in demonstrating the effectiveness of the contract as a tool in the beginning of the treatment process and as a vehicle for symptom cure, suggests the need for further investigation in order to expand and confirm the effectiveness of the contract with larger samples in both individual and group treatment settings and to develop additional details regarding population characteristics.

APPENDIX

Appendix 1


SOUTH DUPAGE COUNTY
$1.95
WEST SUBURBAN CHICAGO
LAKE MICHIGAN
CHICAGO LOOP
EVANSTON
SKOKIE
CHICAGO
OAK PARK
CICERO
BERWIN
MIDWAY AIRPORT
FRANKLIN PARK
MAYWOOD
O'HARE INT'L AIRPORT
WESTCHESTER
LA GRANGE
WESTERN SPRINGS
ELMHURST
OAK BROOK
HINSDALE
LOMBARD
GLEN ELLYN
DOWNERS GROVE
ARGONNE NAT'L LABORATORY
WHEATON
WOODRIDGE
LISLE
NAPERVILLE
WARRENHURST
EOLA
AURORA
DETAILED STREET MAP OF THIS AREA
WEST SUBURBAN TOWNSHIPS INCLUDED ON THIS MAP
BOLINGBROOK
BROOKFIELD
BURR RIDGE
CLARENDON HILLS
COUNTRYSIDE
DOWNERS GROVE
EOLA
HIGHLAND HILLS
HINSDALE
HOCKINS
INDIAN HEAD PARK
LA GRANGE
LA GRANGE PARK
LISLE
LYONS
NAPERVILLE
OAKBROOK
OAK BROOK TERRACE
RIVERSIDE
SUMMIT
WARRENHURST
WARRENVILLE
WESTCHESTER
WESTERN SPRINGS
WESTMONT
WILLOW SPRINGS
WILLOWBROOK
WOODRIDGE
© CREATIVE SALES CORP

NORTH DUPAGE COUNTY
$1.95
WEST SUBURBAN CHICAGO
CHICAGO LOOP
LAKE MICHIGAN
GARY, INDIANA
CHICAGO
MIDWAY AIRPORT
OAK PARK
CICERO
BERWIN
MAYWOOD
FRANKLIN PARK
O'HARE INT'L AIRPORT
OAK BROOK
BENSENVILLE
ELMHURST
VILLA PARK
DOWNERS GROVE
ELK GROVE VILLAGE
ITASCA
ADDISON
LOMBARD
GLEN ELLYN
GLENDALE HEIGHTS
WHEATON
BLOOMINGDALE
CAROL STREAM
WINFIELD
SCHAUMBURG
HANOVER PARK
STREAMWOOD
BARTLETT
WEST CHICAGO
WAYNE
GENEVA
CHARLES
ELGIN
DETAILED STREET MAP OF THIS AREA
WEST SUBURBAN TOWNSHIPS INCLUDED ON THIS MAP
ADDISON
BARTLETT
BENSENVILLE
BERKELEY
BLOOMINGDALE
CAROL STREAM
CLOVERDALE
ELMHURST
LOWERFIELD
GLENDALE HEIGHTS
GLEN ELLYN
HILLSIDE
ITASCA
KENNETVILLE
LOMBARD
MEDINAH
NORTHLAKE
OAK BROOK
ROSELLE
VILLA PARK
WAYNE
WEST CHICAGO
WINFIELD
WHEATON
WOOD DALE
YORK CENTER
© CREATIVE SALES CORP

Appendix 2

AS ADVERTISED

IN THE

Glendale Heights Star
Bloomingdale Star
Roselle Star

Searching for people...

Who are concerned about themselves due to a drinking problem and who are interested in changing their pattern of alcohol abuse. This is part of a research study entitled...

THE USE OF THE CONTRACT IN THE TREATMENT OF PERSONS WHO ABUSE ALCOHOL.

32 people are needed to participate in 12 free weekly counseling sessions. Individual and group counseling sessions begin on

DECEMBER 22, 1979

and will terminate in early March. Confidentiality and amenities are assured.

If you are interested in knowing more about this study and are willing to participate...please call...

BOB FABINO
858-1616

Mon.-Fri. 9 a.m. - 8 p.m. for interview appt.
INTERVIEWS WILL BE HELD ON
DECEMBER 14, 15, 16
532-34 Crescent Blvd. • Suite 202
Glen Ellyn, Ill.
60137

Robert A. Fabino, M.A.

532-34 Crescent Blvd., Suite 202
Glen Ellyn, Illinois 60137
(312) 858-1616

WANTED

WANTED

WANTED

WANTED

WANTED

I am searching for people who are concerned about themselves due to a drinking problem, and who are interested in changing their pattern of alcohol abuse. This is part of a research study entitled:

The Use of the Contract in the
Treatment of Persons Who Abuse Alcohol

Thirty-two (32) people are needed to participate in twelve (12) free weekly counseling sessions. Individual and Group counseling sessions begin on December 22, 1979 and will terminate in early March. Confidentiality and anonymity are assured.

If you are interested in knowing more about this study and willing to participate, please call Bob Fabino at 858-1616, Monday through Friday, 9:00 A.M. to 8:00 P.M. for an interview appointment. Interviews will be held on December 14th, 15th, and 16th, 1979.

Appendix 4

Robert A. Fabino, M.A.

532-34 Crescent Blvd., Suite 202
Glen Ellyn, Illinois 60137
(312) 858-1616

PERSONAL HISTORY QUESTIONNAIRE

Name _____

Date _____

Appendix 4

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTY _____

BIRTHDAY _____ AGE _____

SEX (check one) MALE _____ FEMALE _____

RACE (check one) CAUC. _____ BLACK _____

HISPANIC _____ OTHER (explain) _____

MARITAL STATUS (check one) SINGLE _____

MARRIED _____ DATE _____

DIVORCED _____ DATE _____

WIDOW(ER) _____ DATE _____

FAMILY MEMBERS (Include Children)	RELATIONSHIP	AGE	LIVING or DECEASED	CAUSE of DEATH

EDUCATIONAL EXPERIENCES

NAME of INSTITUTION	FROM_____TO_____	HIGHEST GRADE COMPLETED	DEGREE or CERTIFICATE

OTHER EDUCATIONAL EXPERIENCES:

EMPLOYMENT AND EARNINGS HISTORY

ORGANIZATION	FROM_____TO_____	POSITION TITLE	BRIEF DESCRIPTION OF RESPONSIBILITIES & DUTIES	EARNINGS BEG._____ENDING_____

EXPERIENCE IN COUNSELING OR THERAPY

THERAPIST'S NAME	INSTITUTION	FROM_____TO_____	DESCRIBE BENEFITS (negative or positive)	REASONS FOR TERMINATION

DRINKING AND DRUG PATTERN HISTORY

DRUG(S) USED	BEGAN_____STOPPED____	CURRENT USE		
		Daily	Weekly	

NAME_____ DATE_____

Cage Questions

	Yes	No
1. Have you ever felt you should cut down on your drinking?	___	___
2. Have people annoyed you by criticizing your drinking?	___	___
3. Have you ever felt bad or guilty about your drinking?	___	___
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?	___	___

Michigan Alcoholism Screening Test

Directions: If a statement says something true about you, put a check in the nearby space under YES. If a statement says something not true about you, put a check in the nearby space under NO. Please answer all the questions.

	Yes	No
1. Do you feel you are a normal drinker?	___	___
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	___	___
3. Does your wife/husband (or parents) ever worry or complain about your drinking?	___	___
4. Can you stop drinking without a struggle after one or two drinks?	___	___
5. Do you ever feel bad about your drinking?	___	___
6. Do friends or relatives think you are a normal drinker?	___	___
7. Do you ever try to limit your drinking to certain times of the day or to certain places?	___	___
8. Are you always able to stop drinking when you want to?	___	___
9. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	___	___
10. Have you gotten into fights when drinking?	___	___

MAST--Continued

		Yes	No
11.	Has drinking ever created problems with you and your wife/husband?	___	___
12.	Has your wife/husband (or other family member) ever gone to anyone for help about your drinking?	___	___
13.	Have you ever lost friends (girlfriends or boyfriends) because of your drinking?	___	___
14.	Have you ever gotten into trouble at work because of your drinking?	___	___
15.	Have you ever lost a job because of your drinking?	___	___
16.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	___	___
17.	Do you ever drink before noon?	___	___
18.	Have you ever been told you have liver trouble?	___	___
19.	Have you ever had delirium tremems (DTs), severe shaking, heard voices or seen things that were not there after heavy drinking?	___	___
20.	Have you ever gone to anyone for help about your drinking?	___	___
21.	Have you ever been in a hospital because of your drinking?	___	___
22.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?	___	___
23.	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergymen for help with an emotional problem in which drinking played a part?	___	___
24.	Have you ever been arrested, even for a few hours, because of drunken behavior?	___	___
25.	Have you ever been arrested for drunk driving or driving after drinking?	___	___

Appendix 6

NO DRINKING CONTRACT

DATE _____

NAME _____

I have decided and choose to drink no alcohol from _____ to _____.

This contract is an agreement between (name) _____ and (name) _____.

Signed _____

Signed _____

Appendix 7

REPEATED MEASURES EXPERIMENTS

A: Group No. / Levels of Factor A	B: Time of Testing Levels of Factor B Pre	Post
1		
2		

In this kind of experiment, comparisons between treatment combinations at different levels of factor A involve differences between groups as well as different associations within factor A. On the other hand, comparisons between different levels of factor B at the same level of A do not involve differences between groups. Since measurements included in the latter comparisons are based upon the same subjects, main effects associated within such subjects tend to cancel. For the latter comparison, each subject serves as its own control with respect to such main effects. In an experiment of this type, the main effects of factor A are said to be completely confounded within differences between groups. On the other hand, the main effects of factor B, as well as the AB interaction, will be shown to be free of such confounding. Tests on B and AB will generally be considerably more sensitive than tests on the main effects of factor A. Where no confounding within the group factor is present, there are fewer uncontrolled sources of error variance. The smaller the error variance, the more sensitive (powerful) the test. --Winer

LIST OF REFERENCES

Books

AMA. Manual on alcoholism. American Medical Association, 1968.

Alcoholics Anonymous. Profile on an AA meeting. New York: Alcoholics Anonymous World Services, Inc., 1972.

Berne, E. Transactional analysis in psychotherapy. New York: Grove Press, Inc., 1961.

_____. Games people play. New York: Grove Press, Inc., 1964.

_____. What do you say after you say hello? New York: Grove Press, 1972.

Cahalan, D. Problem drinkers. San Francisco: Jassey-Bass Publishers, 1970.

Chafetz, M. E. Addictions III, alcoholism. Comprehensive textbook of psychiatry. Baltimore, MD.: Williams and Wilkins Co., 1967.

Chafetz, M., Howard, B., and Hill, M. Frontiers of alcoholism. New York: Science House, 1970.

Clark, Kenneth B. Dark ghetto. New York: Harper and Row, 1965, 131-132.

Erikson, Erik H. Identity: youth and crisis. New York: W. W. Norton, 1968.

Forrest, G. G. The diagnosis and treatment of alcoholism. Springfield, Ill.: Charles C. Thomas, 1973.

Fox, Ruth. Aspects of alcoholism, Vol. 2. Philadelphia: J. B. Hippincott Company, 1966.

Freud, S. Collected Papers, Vol. IV. London: Hogarth Press, 1925.

Gelman, G. I. P. The sober alcoholic: an organizational analysis of Alcoholics Anonymous. New Haven, Conn.: College and University Press, 1964.

Goldstein, Arnold P. Therapist--patient expectations in psychotherapy. New York: Pergamon Press, 1962.

Harris, T. A. I'm ok - you're ok. New York: Harper and Row, 1967.

Haykin, M. D. Transactional analysis and the treatment of alcoholism Saint Louis, Mo.: C. V. Mosley, 1977.

Hilgard, E. R. and Marquis, D. G. Conditioning and learning. New York: Appleton-Century-Crofts, Inc., 1961.

Hill, M. H. and Blane, H. T. Evaluation of psychotherapy with alcoholics.

Jellinek, E. M. The disease concept of alcoholism. New Brunswick, N. J.: Hillhouse Press, 1960.

Knapp, R. R. Handbook for the personal orientation inventory. San Diego, California: Edits Publishers, 1976.

Lewin, K. Contributions to psychological theory. Durham, N. C.: Duke University Press, 1938.

Mann, M. Primer on alcoholism. New York: Holt, Rinehart and Winston, 1958.

Meeks, D. Family therapy. New York: Addisor-Wesley, 1976.

Mendelson, J. H. and Mello, N. K. The diagnosis and treatment of alcoholism. New York: McGraw-Hill Book Co., 1979.

Merton, R. K. Social theory and social structure, Glenco, Ill.: Free Press, 1957.

Paley, W., Lea, G., and Vilie, G. Alcoholism: a treatment manual. New York: Gardner Press, Inc., 1979.

Pattision, E. Mansell, Sobel, Mark B., and Sobell, Linda C. Emerging concepts of alcohol dependence. New York: Springer Publishing Company.

Rosenthal, R. Experimenter effects in behavioral research. New York: Appleton-Century-Crofts, 1966.

Rosenthal, R. and Jacobson, L. Pygmalion in the classroom. New York: Holt, Rinehart and Winston, 1968.

Ross, S. M. Behavioral group therapy with alcohol abusers. Springfield, Ill.: Charles C. Thomas, 1974.

Steiner, Claude M. Games alcoholics play. New York: Grove Press, 1972.

_____. Scripts people live. New York: Grove Press, 1974.

Talman, E. C. Purposive behavior in animals and men. New York: Appleton-Century-Crofts, 1932.

Walman, B. and Benjamin B. The therapists' handbook. New York: Van Nostranal Reinhild Company, 1976.

Watzlausisk, P., Beauin, J. H., and Jackson, D. D. Pragmatics of human communications. New York: W. W. Norton and Co., Inc., 1967.

Winer, B. J. Statistical principles in experimental design. New York: McGraw-Hill Book Co., 1962, 46-378.

Zimberg, S., Wallace, J., and Blume, S. B. Practical approaches to alcoholism psychotherapy. New York: Plenum Press, 1978.

Periodicals

Anderson, D. J. A history of our confused attitude toward beverage alcohol. Mayo Clinic Proceedings, 1967, 705-723.

Bacon, S. D. The classic temperance movement of the U.S.A.: Import today on attitudes, action and research. British Journal Addiction, 1967, 62, 5-18.

Beijk, J. Expectancy, performance and self-concept. Acta Psychologica, 1966, 25, 381-388.

Berne, E. Ego states in psychotherapy. American Journal of Psychotherapy, 1956, 11, 293-309.

Braun, J. R., and Asta, P. A. A comparison of "real" versus "ideal" self with a self-actualization inventory. The Journal of Psychology, 1969, 72, 159-164.

Braun, J. R., and LaFaro, D. A further study at the fakability of the personal orientation inventory. Journal of Clinical Psychology, 1969, 25, 296-299.

C., Bill. The growth and effectiveness of Alcoholics Anonymous in a southwestern city. Quarterly Journal of Studies on Alcohol, 1965, 26, 279, 284.

Cattington, F., Grader, M., and Zechnich, R. Treatment of alcoholism. TAB, 1969, 8:32, 92-94.

Coven, A., Blackhawk, E. Gestalt polarities: understanding and counseling the resistant, nonmotivated drug-dependent person. Journal of Drug Issues, 1978, 8, 427-433.

D'Andrea, V.J. Psychoactive drugs and transactional analysis. Transactional Analysis Journal, 1977, 7:3, 242-247.

Ditman, K. S. A controlled experiment on the use of court probation for drunk arrests. American Journal of Psychiatry, 1967, 124, 160-163.

Gellert, S. D., Wilsen, G. Contracts. Transactional Analysis Journal, 1978, Vol. 8, 10-15.

Jelinek, E. M. Phases of alcohol addiction. Quarterly Journal of Studies on Alcohol, 1952, 13, 673-684.

Keller, M. Definition of alcoholism. Quarterly Journal of Studies on Alcohol, 1960, 21, 125-134.

Kepner, E. Application of learning theory to the etiology and treatment of alcoholism. Quarterly Journal of Studies on Alcohol, 1964, 25, 179-291.

King, Albert S. Experimenter expectancy effects in organizational change. Administrative Science Quarterly, 1974, 19(2):221-230.

Klovetter, R. E. and Mogor, R. E. Stability and internal consistency of a measure of self-actualization. Psychological Reports, 1967, 21:422-424.

Kryotal, H. The problem of abstinence by the patient as a requisite for the psychotherapy of alcoholism II. The evaluation of the meaning of drinking in determining the requirement of abstinence by alcoholics during treatment. Quarterly Journal of Studies on Alcohol, 1962, 23, 112-122.

Krechevsky, I. Hypothesis in rats. Psychological Review, 1932, 39, 516-532.

Kupfer, David. Advances in group treatment. TAB, 1966, 5:20, 180-181.

Lawson, D. M. and May, R. B. Three procedures for the extinction of smoking behavior. Psychol. Rec., 1970, 20:151-157.

Leake, G. J. and King, A. S. Effect of counselor expectations on alcoholic recovery. Alcohol Health and Research World, 1977, 1(3), Spring, 16-22.

Miller, P. M. Use of behavioral contracting in the treatment of alcoholism: A case report. Behavior Therapy, 1972, 3, 593-596.

Mortimer, R. G., Filkins, L. D., Kerlon, M. W., and Lower, J. S. Psychometric identification of problem drinkers. Journal of Studies on Alcohol, 1973, 34:1332-1335.

National Council on alcoholism. Criteria Committee. Criteria for the diagnosis of alcoholism. American Journal of Psychiatry, 1972, 129:127-135.

Newmeyer, J. and Johnson, G. Drug emergencies in crowds: an analysis of "rock medicine," 1973-1977. Journal of Drug Issues, Spring, 1979, 9, 2:235-245.

Selzer, M. L., Vinokur, A., and VanRoorjen, L. A self-administered Short Michigan Alcoholism Screening Test (SMAST). Journal of Studies on Alcohol, 1975, 36:1, 117-125.

Shostrom, E. L. An inventory for the measurement of self-actualization. Educational and Psychological Measurement, 1964, 24, 207-218.

Steiner, Claude M. Scripts and counterscripts. TAB, 1966, 5:18, 133-135.

_____. Alcoholism. TAB, 1966, 8:32, 96-97.

_____. The treatment of alcoholism. TAB, 1967, 6:23, 69-71.

_____. The alcoholic game. Quarterly Journal of Studies on Alcohol, 1969, 30, 921-938.

Tiebout, H. M. The act of surrender in the therapeutic process with special reference to alcoholism. Quarterly Journal of Studies on Alcohol, 1949, 10, 48-58.

_____. Alcoholics Anonymous - An experiment of nature. Quarterly Journal of Studies on Alcohol, 1961, 22, 52-68.

_____. Surrender versus compliance in therapy with special reference to alcoholism. Quarterly Journal of Studies on Alcohol, 1953, 14, 56-68.

_____. The role of psychiatry in the field of alcoholism. Quarterly Journal of Studies on Alcohol, 1951, 12, 52-57.

_____. Direct treatment of a symptom. Problems of Addiction and Habituation, 1973, 12, 3-11.

Vannicelli, M. Treament contracts in an inpatient alcoholism treatment setting. Journal of Studies on Alcohol, 1979, 40, 457-471.

Weir, W. R. and Gade, E. M. An approach to counseling alcoholics. Rehabilitation Counseling Bulletin, 1969, 12, 227-230.

Zimberg, J. S. and Weir, W. R. A comparison of alcoholics and selected samples of non-alcoholics in terms of a positive concept of mental health. Journal of Social Psychology, 1967, 71, 151-157.

Reports

Brown, R. J. The influence of a contract approach and/or enounter groups on attitudes toward self and others. Ph.D. dissertation, Ohio University, 1972.

Carroll, Jerome F. X. Mental illness and addiction: perspectives which overemphasize differences and in commonalities. Conference paper-11th Annual Eagleville Conference, May, 1978.

Giles, P. G. The use of contracts to facilitate transfer of training in laboratory training groups. Ph.D. dissertation, University of Oregon, 1972.

Hoff, E. C. The alcoholisms. Paper presented at the 28th International Congress on Alcohol and Alcoholism, Washington, D.C., September 15-20, 1968.

Kinder, Kuche, Kirsch. As scientific psychology constricts the female. Dr. Naomi Weisstein. Paper read at Davis, University of California meeting of the American Studies Association, October 26, 1968.

Korman, I. B. The effectiveness of contractual management in weight reduction groups. Ph.D. dissertation, University of Oregon, 1972.

Room, R. Assumptions and implications of desire concepts of alcoholism. Paper presented at the 29th International Congress on Alcoholism and Drug Dependence, Sydney, February, 1970.

Stern, B. F. The effect of an explicit treatment contract in an alcohol inpatient setting. Ph.D. dissertation, Boston College, 1974, 195 pp.

Third Special Report to the U.S. Congress on Alcohol and Health. Editor: Ernest P. Noble, 1978.

Weir, W. R. "The use of a measure of self-actualization in the treatment of alcoholics and their spouses in an out patient agency." Master Thesis, University of North Dakota, 1965.

Speech

Cassady, J. L. Use of parents and contract therapy in rehabilitating deliquent adolescents involved in drug and alcohol abuse. Alcohol and Drug Abuse Association of North America, Chicago, Illinois, September, 1975.

Unpublished

Cohen, H. A. Contracts, 1976.